CHILDREN'S PERCEPTIONS AND EXPERIENCES OF BEING SENT TO RESPITE CARE FOR SHORT-TERM STAYS

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Abstract

The objective of the current study was to investigate New Zealand children's perceptions and experience of short-term respite care provided as a support intervention for disadvantaged families. An exploratory study was carried out, given that the topic is vastly under explored. The objective was investigated by way of a small qualitative study of eight children attending a South Island–based respite care organisation (SIRCO), using Interpretative Phenomenological Analysis. Analysis revealed six themes evident in the children's interviews: constructive experiences during the stay; adverse experiences during the stay; self-beliefs about why they stay at the SIRCO; attendance autonomy; wanting to help their parents and feeling responsible for their parents' wellbeing; and finally emotional adjustment to stay. Overall, these themes suggested that although the children mostly enjoyed their stays, there were some significant areas which were of concern regarding their perception or experience of attending. As there is a lack of evidence around children's perceptions and experiences of respite care due to limited research, the positives and potential negative ramifications are discussed. The six themes uncovered in this study highlighted areas in which respite care facilities could modify policies to consider these findings and make practical changes. Potential further studies are outlined and recommended.

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Acronyms

Alphabetical

IPA - Interpretative Phenomenological Analysis

RHA - Regional Health Authorities

SIRCO - South Island–based respite care organisation

CHAPTER 1

Introduction

What is respite care?

Respite care is a service that provides caregivers a brief period of time in which their dependants are cared for by somebody else (Cooper, 2014; O'Brien, 2001). When the term respite care is used in 2021, it is associated with a broad scope of situations: foster care, medical care, elderly care and so on; but its origin is not as broad. Respite care was first introduced to support families and caregivers of those who suffered from severe intellectual or physical handicaps. It was also commonly implemented, and still is, with the elderly who suffer from dementia or other debilitating diseases that do not allow them to care for themselves anymore (Weir-Gertzog, 2019). Thus, traditionally, respite care has been defined as: "the shared care of a person with an illness or disability, either at home, in the community, or in a short-term residential setting, in order to give the family a break from the routine of caregiving." (Treneman, Corkery, Dowdney, & Hammond, 1997, p. 548). The focus of this thesis, however, will be on short-term respite care for children, provided as a support intervention for disadvantaged families. The landscape of this form of respite care is continually evolving to reflect and implement new understandings of developmental psychology and best practice for working with children. In the present day, there are many different models of respite care — In-home, Out-of-Home, Group homes, Specialized Facilities, Emergency, Sitter-Companion Services — all with a range of methods and practices (Pollock, Law, King, & Rosenbaum, 2001).. While the models may vary, when considering respite care for children, the underlying ideology of working with children should originate from ethical, developmentally attuned and

child friendly care, with an understanding that it will benefit the family and the child (Perry & Hambrick, 2008).

History of respite care for children

Respite care as a service was not always provided in the same manner it is today (Ministry of Health NZ, 2018; Rugg, 1984). The range of facilities and methods seen today stem from the history of institutions that were built in countries around the globe since the 18th century (Grob, 1973). Before this time, it was seen as the responsibility of the family and community to care for disabled individuals (Grob, 1973). However, during the industrial revolution in England and Colonial America, the population size of cities and urban centres increased rapidly, giving rise to the disabled population as well. In an attempt to deal with this rise, during the middle of the 1800s there began a flurry of institutions built by governments around the western world to house those that did not fit what was considered 'fit for society', which included a large number of children (Chupik & Wright, 2006; Rugg, 1984). This was, in part, due to the minimal understanding of the needs of children who were developmentally delayed or disabled and what would be most beneficial for them (Chupik & Wright, 2006; Ministry of Health NZ, 2018; Rugg, 1984). These institutions became more prevalent in the late 18th century and into the 19th century — some even in the form of workhouses (Grob, 1973).

The institutions were strict and clinical places that were not only unsuitable for young children but dehumanised them. The children were not allowed personal belongings; sleeping areas had over fifty persons in them; and common areas used during the day were overcrowded (Rugg, 1984). These inhumane conditions led to poor outcomes, and there were even numerous scandals of abuse that were reported (Read, 2008). Despite this, these institutions continued into the late 1940s when overcrowding led to a resurgence of construction on the facilities to

expand their size and capacity (Rugg, 1984). Over this time, the quality of care for the patients improved — relative to the horror that had preceded it — but the effectiveness of this model of care began to be questioned more critically by families and researchers alike, especially as associations of the preceding conditions remained in the public's mind (Rugg, 1984). Even still, the modern and improved institutions, designed to provide quality medical care and treatment for those with intellectual handicaps, were overwhelmingly used into the 1960s (O'Brien, 2001; Rugg, 1984; Strunk, 2010).

Later inquiries by governmental departments around the western world into institutions' effectiveness found there to be limited evidence in support of them. The admission was made by the Public Welfare department in the United States that institutionalisation "might not necessarily be in the best interests of the family or mentally deficient child" (Rugg, 1984, p. 43). With this came a growing pressure to provide community-based forms of care for individuals with disabilities, and researchers began discussing and studying the beneficial effects that this care might have on the patients. John Bowlby — British psychologist, psychiatrist, psychoanalyst and expert in the field of child development — incited change with his arguments against the use of these institutions, due to their negative impact on children's development (Read, 2008). He emphasised that for a child to develop healthy outcomes, they needed to live in a family environment (Read, 2008). However, at the time there were inconsistent or non-existent community supports for families with intellectually disabled children due to funding being allocated to institutions, meaning such a transition would be extremely under resourced (Rugg, 1984). The significant cost, therefore, initially slowed down the transition to this new progressive model (Rugg, 1984). However, there was also the recognition that the high monetary cost of institutionalising individuals could be reduced with a more cost-effective service if the individuals were integrated back in to society (Read, 2008; Rugg, 1984). Eventually, successful lobbying efforts against these institutions by parents of

disabled children and researchers of the field led to a widespread introduction of community group homes that became prevalent from the 1970s onwards (O'Brien, 2001; Rugg, 1984).

This was the beginning of deinstitutionalisation — as many children, young persons, and adults who had been committed were then sent to live in community homes and, in cases that were considered 'mild' or 'moderate', back into their family home (Rugg, 1984). Some institutions helped these people transition back into the community by introducing specialised services which provided support and respite care to families who now had fulltime care of their intellectually disabled children (Rugg, 1984). Other community and governmental projects also began to be initialised to offer respite to these families (Rugg, 1984). These new respite care services that were being formed were also developed in New Zealand, helping families get the support that they needed without the complete removal of their child from their lives (Ministry of Health NZ, 2018b).

New Zealand's history of respite care for children

New Zealand's history of respite care support followed that of the rest of the world with a transition period into the mid-1970s from institutions towards community-based and rights-based care (Ministry of Health NZ, 2018b). The New Zealand government recognised that, with the deinstitutionalisation of disabled people and children, the need for support would be substantially higher now in the community (Ministry of Health NZ, 2018b). The support and care that had previously been provided daily at these facilities was now expected to be undertaken by family members and caregivers, which was a significant responsibility. As the once-institutionalised individuals were moved into community based residences, and in some cases families and caregivers' homes, it was recognised that the carers themselves would have a high burden of care; thus, a resolution was needed to alleviate it (Geiser, Hoche, & King, 1988). The burden of care refers to the impact to the parents'/guardians'/foster parents'

physical, emotional, social and financial state because of caring for a child with high needs (O'Neill & Ross, 1991). To addresses this burden of care a significant piece of legislation was passed that assisted this process, named the Disabled Persons Community Welfare Act 1975 ("The Disabled Persons Community Welfare Act," 1975). This Act brought with it the concept of 'relief' from the responsibility of looking after disabled children who were under the care of their parents or guardians. The 'relief' offered to these families by the New Zealand government demonstrated an effort to share the responsibility of helping care for those individuals and families, via monetary contributions that would fund up to four weeks of relief per year (Ministry of Health NZ, 2018b). This relief was an early form of what we now consider respite care, and it was a sizeable acknowledgment for these families at the time.

During the 1980s and 1990s improvements were made upon the system to offer easier access to disability services. The New Zealand Government introduced a formal contracting system to purchase disability services. This system replaced government grants to charities and other organisations that were used for these services (Ministry of Health NZ, 2018b). This had a flow on effect on charitable organisations within the sector, which then had to become reliant on other forms of financial support. In 1992 the announcement of a 'new deal' for persons with disabilities was initiated, with each of the Regional Health Authorities (RHAs) taking the lead for services within their region. By 1995 the transition of the disability care had been distributed to each of the RHAs. Once this had occurred, RHAs began to purchase properties to create respite support (Ministry of Health NZ, 2018b). This was a facility-based respite care initiative that was accessible predominantly for children for overnight accommodation in dedicated housing. Each of the RHAs conducted this differently, the Auckland and Waikato RHAs created specialised respite support housing for children with disabilities and complex needs (Ministry of Health NZ, 2018b). For other areas, in particular the Central and Southern regions, they contracted a national provider to build these respite care units. Also, amidst this

major change in community respite care, the RHAs also financed care specialised for in-home and buddy support for disabled persons, providing them one-on-one care (Ministry of Health NZ, 2018b).

Since the 90s the Government has reformed legislation and made the Ministry of Health responsible for disability support funding which saw respite care centrally funded from 2001. More dedicated respite care facilities began to be built in 2006 after the Ministry of Health mandated it (Ministry of Health NZ, 2018b). This was expanded again in 2014 with the introduction of Individualised Funding Respite, also known as IF Respite (Ministry of Health NZ, 2018b). This provided families with disabled children more support and has given many families extra hands to help care for these children. With respite care expanding, numerous studies have investigated it, with the literature suggesting the importance of parents/caregivers having access to respite care to alleviate the consequences of full-time caring for those with a high level of needs (Cooper, 2014; O'Brien, 2001; Strunk, 2010).

The expansion of what constitutes as ‘significant burden of care’, resulting in the ability to access respite care has been a major improvement in parents’ lives (Strunk, 2010). This change was made as a way of helping the family cope with the burden of care (Nageswaran, 2009). Both parents of children with disabilities and foster carers have reported that it is one of the most needed services (Madden et al., 2016; Nageswaran, 2009; Perrin, Lewkowicz, & Young, 2000). These authors suggest that the reasoning for this is that these children often require more time and energy from the parents/carers to achieve the same outcomes. Whitmore (2017) echoes this but also puts forward that just because a child is not physically disabled or intellectually disabled does not mean that the parents will not require support or help.

Respite care for fulltime foster carers

Respite care has developed and changed significantly over time, adapting with societal and cultural shifts, extensive research, and an increased understanding of what works to give parents/caregivers/guardians the ability to care effectively. , Because of these various factors, the definition has widened to include a range of circumstances. For example, a significant number of children who are placed into respite care for short-term stays are those who live full-time with foster carers (Meloy & Phillips, 2012). This is much like the history of respite care where, in the 1700s, children who were abandoned or orphaned were originally adopted by community members. Eventually, as institutions began to be built, so did places which were to house the multitude of children who were unwanted or orphaned (Hacsi, 1995). With the deinstitutionalisation that occurred in the mid-to-late 20th century, the number of children being placed in foster care rose rapidly. The rising prevalence of abuse and neglect was a significant contributing factor, leading to the eventual removal of many children from abusive households (Hacsi, 1995). The 1962 publication on "The Battered Child Syndrome" reflected this emerging concern (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962).

Child abuse in the 21st century has still not been eradicated; and unfortunately, of those children maltreated, only a small proportion are reported, verified, and placed into care (Ministry of Jusitice NZ, 2015). Much research has shown that abuse and neglect can be significant factors as to why children's development may be severely impeded or maladaptive (Kefeli, Turow, Yıldırım, & Boysan, 2018; Taillieu, Brownridge, Sareen, & Afifi, 2016; Tarren-Sweeney, 2016). Foster carers often care for children who have suffered sexual, emotional, physical abuse, or neglect at their biological parents' homes. Of those, a small proportion suffer such a high level of trauma and are so developmentally damaged that they require an ongoing need for care. "These are children who tend to experience more severe, more chronic, more pervasive and more diverse maltreatment." (Tarren-Sweeney, 2016, p.

499). Tarren-Sweeney (2016) continues to discuss the clear and significant impairments that are apparent with children who have been neglected to this extent. For the majority of abused children, they do not need extended individual sessions with a psychologist or similar interventions; what they need most is attuned, responsive, and caring parental figures (Perry & Szalavitz, 2017). This is the role of a foster carer who can have significantly beneficial impacts on the child. Understandably, the psychological and physical trauma that some of these children have experienced does, however, increase the burden of care for the foster carers, which can lead to exhaustion. These tamariki (children) who have been abused in some form have an increased risk of suffering from psychological trauma, manifesting in the form of a disorder/s or physical, intellectual, or emotional disabilities (Kefeli et al., 2018; Taillieu et al., 2016). Some children who are more severely abused require specific full-time or ongoing care, as Tarren-Sweeney (2016) discussed.

For foster carers, the offer of respite is warmly welcomed and well deserved because these traumatised children can be difficult to manage because of their experiences. It is important to highlight that children develop in response to the environment they are raised in, suggesting that they are not responsible necessarily for their poor behaviour, but neither still are their new carers (McCrory & Viding, 2015; Perry & Hambrick, 2008; Tarren-Sweeney, 2016). To mitigate this challenge, foster carers throughout the world are supported by respite care providers who enable them to take a break from parenting in order to protect against burnout (Cooper, 2014; Madden et al., 2016; O'Brien, 2001; Piescher, Schmidt, & LaLiberte, 2008; Verhoef, 2005). There have also been other changes to the foster care system in an attempt to help reduce the parental responsibility assumed by the foster carers. One such change made in the United Kingdom, and subsequently has been adopted elsewhere, was the replacement of the term ‘Foster Parent’ with ‘Foster Carer’, alleviating the connotations that the word ‘parent’ has and the responsibility it brings (Cooper, 2014). Increased support by the

government and other non-government agencies also helped, but ultimately, short-term respite care provided the carers with something that was hard to find elsewhere — a break. Thus, respite care of this kind has become a common practice, with many children having stays in respite care every year (Meloy & Phillips, 2012). This has helped stabilise foster care placements for these children, so that they and their foster carers can maintain a healthy relationship. This can look different for different placements, as there are varying forms of respite; some of the most common are in-home and out-of-home. In-home is where a practitioner provides care in the home while the carers leave and have a break. Out-of-home care is where the child is sent to another home, centre, residence, or camp, giving the carer time to themselves at home. These placements can vary in length of time, from a weekend to several months at a time.

Respite care for families where there is a high risk for child maltreatment

Since the 1970's, it has been increasingly recognised that abuse and neglect could also be impacted by carer stress from economic or social factors (Garbarino, 1976). Researchers began to acknowledge that there was evidence to suggest that parenting circumstances could have an impact on child maltreatment and that respite care could alleviate stress and reduce the risk of harm (Szwarc, 1993). The concept of the carer being supported and given a break from full-time care has stayed the same, but in the subsequent years it has become widely recognised that many different situations have a high burden of care because of a variety of needs. One recent definition reads: "Respite care is temporary relief for caregivers and families who are caring for people with disabilities or other special needs such as chronic or terminal illnesses; or are at risk of abuse and neglect." (Whitmore, 2017). This definition has the inclusion of "risk of abuse and neglect", developing the concept that respite care should be, and is, provided to those families who are in vulnerable situations. This inclusion has allowed many children who

are in vulnerable family situations to receive respite care to minimise their risk of harm and to help parents have a break and care effectively. In this way, respite care provides both a protection service for children and a family support service for families who are disadvantaged, as well as foster families and families with children with disabilities (Carnochan, Rizik-Baer, & Austin, 2013; Cashmore, 2014; Cooper, 2014; Cowen & Reed, 2002; Day et al., 2018; Team, Price, Kirkwood, Campbell, & Ray, 2020). However, when maltreatment is evident, emergency stays at respite care services can be used to protect the child (Carnochan et al., 2013; Palusci, 2011). Removal from the abusive households is immediate, and placements into temporary foster care or other emergency respite is arranged. Before this occurs, families who are at risk of maltreating their child can be offered respite care as a preventative measure to decrease parental stress and risk of abuse (O'Brien, 2001). For families who are considered at risk of child abuse and/or neglect, this precautionary measure can be vital.

Families who are at risk of maltreating their children often have difficult and stressful lives, having a high risk of adverse outcomes due to family separation and breakdown, unemployment, poor education, poor mental or physical health, and disability (B. Drake & Jonson-Reid, 2014; Read, 2008). It must be noted, however, that not all families who use respite care are at risk of abusing their children, and parental deficiencies may have resulted from a cycle of abuse that was experienced during the parents' own childhood (Michl-Petzing, Handley, Sturge-Apple, Cicchetti, & Toth, 2019). Ultimately, these are families who are socially disadvantaged and are considered vulnerable; often the parents have a lack of skills, abilities, or capacity to parent effectively (B. Drake & Jonson-Reid, 2014; Kissman, 1999; Read, 2008). This explains how there are many reasons for the use of respite care and those mentioned above depart from the traditional view of what necessitates it — as it is not exclusively due to the high burden of care generated by the *child* (because of illness or

disability), but rather, it is due to the *caregiver's* own parenting limitations, or a combination of both (O'Brien, 2001).

Families who are at a higher risk of abusive parenting styles also have an increased chance of reporting that their child is more difficult to handle, perceiving greater behavioural difficulties even when there are no differences between their child and those in other families (Farc, Crouch, Skowronski, & Milner, 2008; O'Brien, 2001). This highlights the impact that poor parenting ability can have on parents' perceptions of their child (and their child's behaviour). Parents who perceived increased behavioural difficulties were also more likely to maltreat their children and express negative perceptions onto the child (O'Brien, 2001). This can lead to the child developing negative internalising and/or externalising behaviours and coping strategies (O'Brien, 2001).

If a child meets the criteria which is considered a burden of care to the parent, either physically or intellectually, then the parents are able (albeit difficult) to receive funding or support from the government for respite care, but families who are socially disadvantaged and have no 'clear' evidence can struggle to find this type of governmental support (McKeown, 2000). Many vulnerable families lack extended family and other social support for sharing caregiving and reducing parents' burden of care (O'Brien, 2001). These families have the same need for the service, yet it can be difficult to obtain; and at times the child can suffer because of it. With disadvantaged families having a higher risk of maltreating their children by child welfare services providing access to respite care organisations it can help reduce this risk (O'Brien, 2001). There are, however, organisations that do not rely solely on a referral by the child welfare system which offer respite to these families. These are for use in family support capacities or for emergencies. There are indications that socially disadvantaged families within the child welfare system who utilize respite care as a family support intervention or child protection intervention can respond well and benefit from the reduced stress (Team et al.,

2020). With these arguments, it is clear to see how respite care provides disadvantaged families support and a protection service for their children. It is also providing these disadvantaged families with relief and a reduction in stress in the same way it does with all other families who have access to respite care.

Benefits of using respite care for caregivers

Respite care for children has been studied in a multitude of settings, showing the relief it can bring and reduction in stress for parents/caregivers who have a significant burden of care (Caples & Sweeney, 2011; Day et al., 2018; Harper, Dyches, Harper, Roper, & South, 2013; Jeon, Brodaty, & Chesterson, 2005; Madden et al., 2016; Piescher et al., 2008; Pollock et al., 2001; Strunk, 2010). These studies have investigated varying populations of parents and foster carers of both disabled and non-disabled children. The benefits for parents/guardians/foster carers when using respite are well understood and far-reaching; some cannot be stated as causational effects but have been associated with respite care. They can be summarized as follows:

- Feelings of needing a break or of relief being met when respite is used to assist caring (Caples & Sweeney, 2011; Cooper, 2014; Eaton, 2008; Jeon et al., 2005; McLennan, Doig, Rasmussen, Hutcheon, & Urichuk, 2012; Piescher et al., 2008; Read, 2008; Schroder, Turner, & Robertson, 2014; Strunk, 2010; Whitmore, 2017; Whitmore & Snethen, 2018)
- Increase to quality of life for parents/guardians/foster carers (Caples & Sweeney, 2011; Eaton, 2008; Jeon et al., 2005; Mansell & Wilson, 2009; Read, 2008; Schroder et al., 2014; Strunk, 2010; Whitmore, 2017; Whitmore & Snethen, 2018)
- Increased self-esteem for parents/guardians/foster carers (Jeon et al., 2005; O'Brien, 2001)

- Lower reported family/parental stress when aided by respite care (Carnochan et al., 2013; Chan & Sigafoos, 2001; Cowen & Reed, 2002; Harper et al., 2013; Madden et al., 2016; Mansell & Wilson, 2009; O'Brien, 2001; Piescher et al., 2008; Read, 2008; Schroder et al., 2014; Strunk, 2010; Treneman et al., 1997; Waters et al., 2017; Whitmore, 2017)
- Decreased risk of burnout (Cowen & Reed, 2002; Piescher et al., 2008)
- Decreased parental fatigue (Cowen & Reed, 2002; Nageswaran, 2009)
- Better parenting/family environment/relationships (Cashmore, 2014; Cooper, 2014; Jeon et al., 2005; Madden et al., 2016; O'Brien, 2001; Perry, 2003; Strunk, 2010; Whitmore, 2017)
- Increased marital quality, possibly lower divorce rates (Harper et al., 2013; Whitmore, 2017; Whitmore & Snethen, 2018)

It is also worth mentioning that there is some credence to the benefit that respite care can have on siblings of those that attend such facilities (Welch et al., 2012). Short breaks promote the wellbeing of the sibling, allowing them to have time with their parents that they might not have had otherwise. As with all literature in this area, studies investigating siblings are also sparse (Welch et al., 2012).

When considering parents' experiences of respite care, there is discussion made regarding the consistency of these findings throughout the literature. The consensus, however, is that there are benefits for families who use respite care, even if there needs to be clarity around the reliability of the practices used (Jeon et al., 2005; Pollock et al., 2001). There has also been discussion in the literature about how if respite care is provided poorly, it can actually increase stress within the family (Whitmore, 2017). The increase in stress is often due to miscommunications between respite centres and parents about what services will be provided for the family and when (Whitmore, 2017). Some families have noted that the areas of most

concern to them were: their referrals to get into respite care, service organisation, communication, and relinquishing control of their children into respite care (Eaton, 2008). Mothers who were anxious about being separated from their child have also shared some concern over prolonged separation which is involved in respite care (Whitmore & Snethen, 2018). Furthermore, in some studies families have expressed that they are embarrassed or guilty about sending their children away into respite care (Cooke, Smith, & Brenner, 2020; Whitmore, 2017). Finally, the demand for respite care services exceeds available respite capacity, thus adding to the stress (Caples & Sweeney, 2011).

Parents around the globe use respite care to gain the benefits discussed above, however some authors allude to the potential harms of these arrangements for the child. The current study sets out to explore children's voices in these respite care settings to examine their perceptions and experiences. The importance of doing so is that not all respite care placements are safe, as Cashmore (2014), in their study, expressed "concern about children's feelings about and reactions to these arrangements, especially when children are exploited, abused, or discriminated against in these arrangements". In most places where respite care is used, there are protective layers to stop any form of abuse; however, a high level of scrutiny needs to be applied in every context, as the children in question are some of the most vulnerable in any society (Verhoef, 2005).

These varying perspectives and discussions around respite care display how it is unclear exactly how much respite care benefits the family. Overall, there seems to be a majority of positive reports of respite, but respite is an area that lacks large scale empirical evidence to support it, and this is due, in part, to the lack of consistency to the way in which respite care is provided by organisations and facilities (Pollock et al., 2001). Yet, without a consistent model of respite care and with minimal empirical evidence, there are recommendations to use respite care on mass because of the benefits that have been discussed above. The general attitude and

beliefs about the benefits of respite care for parents/caregivers boils down to statements such as this: “Respite is a gift,” and “We get a break” (Whitmore & Snethen, 2018). With this as the basis of our understanding of how respite care benefits parents who are using the service, it is now prudent to investigate the literature on children’s reports of their experiences within respite care.

CHAPTER 2

What is known about the effects of respite care on children's development and well-being: Research and Theory

Part 1: Literature review

Two literature reviews were conducted for this study, the first being on the effects of respite care on children's development and well-being, and the second being on children's views and experiences of respite. The objective was to search the relevant databases and find studies that were relevant to these two areas. After searching the relevant literature, zero studies were found. The search was then widened to include children in respite care in general, for which a total of five articles were found. These were of varying quality and scope and included children from a wide range of populations. A few articles investigating beneficial effects of respite care on parents/guardians/foster carers touched on relevant information regarding children in this area, but they were mostly anecdotal. Thus, the five articles examined highlighted the minimal evidence in this area under investigation.

Literature search procedure

The databases used to search for books and articles pertaining to respite care were PsycINFO, PsycARTICLES, PubMed, Scopus, Google Scholar.

a) Effects of respite care on children's development and well-being

When searching the databases these search terms were used in a number of different combinations: 'respite', 'respite care', 'well-being', 'children', 'child', 'children's development', 'out-of-home care', 'child welfare', 'emergency respite' 'adolescent' 'foster care', 'kid'

b) Children's views and experience of respite

When searching the databases these search terms were used in a number of different combinations: ‘respite care’, ‘short-term respite’, ‘children’, ‘adolescent’, ‘experience’, ‘perception’, ‘emergency respite’, ‘foster care’, ‘out-of-home care’ ‘child welfare’ ‘interviews with children’

To begin with, strict guidelines were set to only investigate children’s perceptions and experiences of specifically short-term respite care organisations. The search parameters were then widened to ‘any respite care centres’, and two studies were identified that investigated children’s perspectives in a residential respite care home. These studies were reviewed intensively, but with the need for more sources to gain a better understanding of the field, the parameters were widened further again. The articles that were accepted were any that studied a form of respite care with children, specifically those that interviewed the child about said respite or considered their point of view. The articles that were selected had to be from peer-reviewed journals and had to have their entire list of references included.

When using advanced search options, extra parameters were used to narrow the search to specifically children and adolescents; this was so that the multitude of studies conducted on dementia patient respite care and other such adult respite care would not be included. Because respite care has changed significantly since the dissolvement of institutions and the move towards community care, only articles published in the last 30 years were used, as in this period new forms of respite care facilities for children were established. When so few articles were able to be found about the children’s personal experiences of short-term respite, this time parameter was taken off to see if any papers had been published before that point. The articles that were within the parameters of the search criteria were investigated for the reason of finding references to other articles pertaining to the current review. These can be seen in Table 1.

Articles identified

Table 1. Articles identified.

Source Information	**Study 1. Read (2008)**	**Study 2. Schroder et al. (2014)**
Type and purpose of respite care	Residential respite care in NZ, for children to have short-term stays at to alleviate family stress.	Short-term residential respite care in NZ for children of disadvantaged families.
Research Topic/Question	Parent and children's experience of short-term residential respite care for children in the context of parental stress.	Facility's role in the community and the impact it has on families' ability to keep children safe.
Methodology	Quantitative: Psychometrics Qualitative: Interviews Participants: Four families	Qualitative: Interviews Participants: 27 children, 25 Carers, 7 staff, and 12 referrer/brokering partners
Findings	Quant: Inconclusive Qual: Beneficial for parents, Negative impact on children and disparity between parent and child's beliefs about stay.	Qual: Mostly positive views of facility for participants. A few areas for improvement of the facility highlighted by participants.
Limitations	Timing of data gathering and the delivery of the quantitative psychometrics.	No reported limitations.
Areas for future Research	Studies addressing children's wellbeing while attending respite facilities.	No reported recommendations.
Source Information	**Study 3. Minkes, Robinson & Weston, (1994)**	**Study 4. Stewart (2017)**
Type and purpose of respite care	Residential respite care in UK for children/adolescents with disabilities to give families respite from burden of care.	Therapeutic respite summer camp in the USA, for children with and without disabilities, giving campers new experiences.
Research Topic/Question	Disabled children's perceptions of residential respite care.	Beneficial effects for children with specific disabilities associated with summer camp.
Methodology	Qual: Interviews Participants: 63 disabled children UK	Quant: Pre & Post Survey Qual: Interviews Participants: 568 Disabled, 122 abled, 22 parents
Findings	Qual: Overall enjoyment of facilities, good relationships with staff/children, some children prefer to be home.	Quant: Increased self-determination/autonomy, self-esteem and relatedness/social acceptance for children in varying groups
Limitations	Interviews were not flexible for children's limited speech, varying quality of interviews.	No reported limitations
Areas for future Research	Children to be able to express views.	Longitudinal studies used to investigate how respite summer camps could affect autonomy, self-esteem, and relatedness over time.

Table 1 cont.

Source Information	**Study 5. Uhrman, Walton, Oakes, Schleien, & Kress, 2019**
Type and purpose of respite care	Summer Camp in the USA for children with and without disabilities, to give the campers an inclusive experience
Research Topic/Question	If disabled children who participate in a photo challenge have increased feelings of inclusion at camp.
Methodology	Qual: Photo challenge analysis and group discussion Participants: 7 Disabled and 7 neurotypical children
Findings	Qual: Children who participated in the photo challenge activity showed and discussed inclusion they felt in the activity
Limitations	Small sample size. Direct questions may influence perception of experience.
Areas for future Research	Recommended exploring the use of photography as a method of self-expression for children who have limited verbal ability.

In total there were five studies that were fit to be reviewed for the current study. These were conducted around the world, considering the experiences and perceptions of children being sent into any form of respite care, particularly focussing on fostered or disabled children (Minkes, Robinson, & Weston, 1994; Stewart, 2017; Uhrman, Walton, Oakes, Schleien, & Kress, 2019).

The few studies that did investigate children's experiences of respite care were diverse. Each care facility/organisation was vastly different from the others — two were organised as camps, one was a multi-location organisation, while a further two were at a single facility. Each paper interviewed the children, so even though the papers were unequivocally different they contained the voices of the children. Limitations of the applicability to the current study is

considered. The first two studies discussed were identified as being most similar to the literature specifically under review; each study after that will be discussed in year order.

Review of the articles

Study 1

The first study to be reviewed was conducted in New Zealand, and it interviewed children and parents/caregivers about their experiences of short-term residential respite care (Read, 2008). Four families and their children were used for the exploratory study, which had a mixed methods design, containing interviews and quantitative measures. The quantitative measures were used to enrich the qualitative data that was being gathered. Their results regarding the quantitative psychometric measures were inconclusive. The authors indicated that their qualitative findings suggested that the families who were using this service were disadvantaged and had low levels of familial or social support and reported greater than average parenting stress. Regarding the children's perspectives, which was the specific part that this review was looking at, the qualitative portion of the study suggested that there was a disparity between the parent and the child's perception of their attendance at the facility. The parent/caregivers/guardians reported during interviews that they found the facility beneficial to their lives, reducing their stress, and they believed that their children also loved going. In three of the four families, however, the children reported that their experiences were often negative, either because of the separation from their mothers (main attachment figures), being bullied, or the disruptive and aggressive behaviours of the other children.

Study 2

The second study to be reviewed was conducted within New Zealand at a short-term respite care centre and interviewed children, parents/caregivers, staff, and referrers/broking partners about their opinions and experiences of the facility (Schroder et al., 2014). The

qualitative methodology used was thematic analysis, formed from semi-structured interviews. The authors interviewed 27 children, 25 adults (from families), 7 staff, and 12 referrer/brokering partners. Of the children they interviewed, the age range was between 6 and 14 and the mean age was 9.8, with a gender split of 16 female and 11 males. The number of stays for participants ranged from 1 to 74 stays between the years of 2009 and 2014. The study discusses in great depth what the carers, referrers, and staff think about the service. Carers saw the facility as vital to the community, aiding in teaching the children valuable life skills. Staff and referrers/brokering partners identified areas of improvement for the service but also noted the aspects in which it excelled and the significant role it played. Comparatively, the section of the study reporting children's experiences was minimal; however, the view and voice of the children were considered. The themes that came from the children's interviews were largely positive, with themes emerging such as enjoying the activities, learning new skills and staff relationships. The only negative theme that arose from the children's interviews were bullying behaviours of other children.

Study 3

A qualitative study of 77 children was conducted in the United Kingdom which sought to evaluate disabled children's perceptions of a residential respite care across six separate centres (Minkes et al., 1994). They interviewed 77 children at these centres, and a total of 63 interviews were included. The children that they interviewed had a range of disabilities, with some having little to no speech. The interviews covered the child's opinion of the respite care centre, their integration with the other children, and the quality of the care at the facility. The results of the interviews showed that, in general, the children seemed to enjoy the facility; they had friends and made good relationships with the staff. The standard of care at each of the six facilities was very high, which was reported by not only participants of the study but by parents/caregivers and researchers from their observations. Countering this general trend, there

were some children who would have preferred to be at home and some who were outright unhappy with their stays at the facility they attended.

Study 4

Stewart (2017) discusses in their paper the vast number of benefits that therapeutic respite summer camps provide for children with disabilities, ranging from experiencing new activities to making new friends. They conducted their study at a three-day camp in southeast Virginia, surveying 682 total subjects, including 568 campers with disabilities, 122 without disabilities and 22 parents. Each of them was given a pre-camp survey and a post-camp survey relating to different areas. These areas relating to children were self-determination theory/autonomy, self-esteem/self-efficacy and relatedness/social acceptance. During the study they measured self-determination theory/autonomy by surveying participants with specifically diabetes between the ages of 6 and 17. They measured on multiple scales and the results showed at the end of camp that there was an increase in areas relating to autonomy. The camper's competency in managing their diabetes improved significantly during the camp, and they felt like they had a better understanding about how to manage their disability. This improvement can be attributed to the higher levels of autonomy support campers reported having while on camp. Stewart (2017) also found that this form of respite care increased self-esteem and feelings of relatedness for the campers that were measured. They suggested that one of the reasons for this was that the individuals at the camp were surrounded by others who also had disabilities, helping them to connect and therefore be less isolated from their peers.

Study 5

A study conducted on children attending summer camps in the United States of America was used to investigate the perspectives of the children who attend (Uhrman et al., 2019). The study was targeted at Jewish summer camps for children with disabilities. The study had 7

dyads, each which consisted of a participant who was classified by the camp as significantly disabled and with them was a neurotypical buddy of roughly the same age. The design of the study was centred around the participants taking part in a photography challenge which was run by the InFocus team. The design involved taking photos after being given the following prompts:

1. Show something you are really good at doing.

2. Show something about camp that is meaningful or valuable to you.

3. Show something that makes you feel connected to Judaism at camp.

4. If you could do one thing to make camp better for you, show what it would be.

The participant dyads were shown these prompts one at a time over the following few days and went about taking photos pertaining to these situations. After taking the photos relating to the prompt, the dyads came back and were able to share them with the other campers. They were also able to describe them and discuss the photos. The study findings, suggested by the authors, emphasized the importance of neurotypical and neuroatypical campers interacting with each other. They discussed how this activity allowed for friendships to develop between the dyads. Uhrman et al. (2019) discuss how the children's perspectives of summer camps could, through this activity, highlight the parts which campers enjoy and feel good about doing in a non-invasive manner.

Benefits of respite care for children

In the limited pool of literature that discusses respite care, the inclusion of the benefits for children from their perspective are even more restricted. These studies discussed above come from a wide range of sources that do not investigate children in the same model of respite or with the same disabilities or complex needs. The benefits listed below are just a vague

picture of the various sources previously discussed. Some listed do not investigate children's experiences or perceptions, but they do validate the importance of respite care for the child. The benefits can be summarized as follows:

- Enjoyment of stay because of activities and making friends with other children and staff (Minkes et al., 1994; Schroder et al., 2014; Stewart, 2017; Uhrman et al., 2019)
- Increased feeling of autonomy, self-efficacy, self-esteem, social acceptance, and relatedness after attending respite camp (Stewart, 2017)
- Surrounded by children who are 'like' them, or are at similar life stages, or face similar 'battles' (Stewart, 2017)
- Catered to the needs of the child (Stewart, 2017)
- Decreased risk of child maltreatment (Carnochan et al., 2013; Cowen & Reed, 2002; O'Brien, 2001; Schroder et al., 2014; Whitmore, 2017)
- Decreased number of children who go into long-term care if families use respite care (O'Brien, 2001)

As seen above, the beneficial effects of respite care from a child's perspective to have been investigated previously are very limited. Three of the studies that were investigated, however, also included negative responses from the child's perspective (Minkes et al., 1994; Read, 2008; Schroder et al., 2014). As the respite care model used in each of the five studies is inconsistent and the age of the children who are interviewed vary in age and developmental stage, it is hard to quantify what children's experiences or perceptions are of short-term respite care. There is, however, in this small body of literature indications that the various forms of residential respite care, camps, and out-of-home care contain some negative factors. These include bullying by other children, missing family or caregivers during their stay, feeling unable to choose when they attend, and poor/strict staff attitudes (Minkes et al., 1994; Read, 2008; Schroder et al., 2014).

It is acknowledged that the studies reviewed are distinct and are, in some ways, not fitting for the current review regarding short-term respite care. With this point considered, the current review aimed at using the meagre findings that even considered children's perspectives as a guide to how children perceive their stays, which then can be referred to when designing the methodology of the current study.

Part 2: Theories that predict the effects of respite care

In the context of respite care, it must be investigated how children who are already considered high risk could perceive being sent away from their family and into the care of strangers. It is not abuse or neglect on the parents'/guardians'/caregivers' part to send their child into respite care, however, it is possible — within our understanding of child development — that these children could perceive otherwise.

Attachment theory

Attachment theory is an important basis when considering respite care and children's experiences and perceptions of it. This is because children who are sent into respite care come from a wide range of families and will have varied forms of attachment relationships with their parents. There is research to indicate that children of families who have limited parenting skills or those children with foster families due to maltreatment have an increased risk of insecure attachments (Baer & Martinez, 2006; Gordon, 2003). Depending on the style of insecure attachment, this could present in feelings of abandonment (Meyer & Pilkonis, 2001). If that is the case, then respite care might perpetuate the already insecure attachment that the child has with their parents/guardians/caregivers. For the current study it is important to consider children who have parents with limited parenting ability and/or come from maltreated backgrounds because of the association it has with insecure attachment (Baer & Martinez, 2006; Gordon, 2003).

Attachment theory is used as a theoretical framework to help researchers understand the relationship children have with their parents or caregivers. This presents the idea that if a child is to flourish, they require healthy and responsive caregiving to form and maintain a secure attachment (Bowlby, 2005). Bowlby was the first to recognise this phenomenon, and since then many researchers have studied and investigated attachment. From the numerous studies, four clear patterns of childhood attachment have been found; these are secure and three forms of insecure: ambivalent (anxious-resistant), avoidant (anxious-avoidant) and disorganized (Mooney, 2009). These patterns are formed during infancy through proximity-seeking behaviours that intend to restore closeness with the parent/caregiver.

The child develops an internal working model that reflects the responsiveness of the parent to these behaviours. Secure attachments are formed between an infant and a sensitive caregiver who is responsive to the child and is aware and attuned to their needs, soothing the child when they need but also able to allow the child the freedom to explore their environment. Sensitive caregivers still only get this right around 50 percent of the time because of life's distractions, but these ruptures can be repaired by future attuned interactions (Howe, 2011). Insecure attachments are formed when the parent's responses are inappropriate to the baby's wants or needs; for instance by trying to socialize when the child is hungry, or play when the child is tired, or feed when the child wants to interact socially (Ainsworth, 1969). Secure attachments form in roughly 55-60% of non-clinical populations and this is consistent across countries (Howe, 2011). In the remaining 45-40% of cases, insecure attachment is formed; and the further it deviates from secure attachment, the greater the dysfunction.

Ambivalent attachment can form in response to unpredictable caregiving. Children who have this form of attachment when observed in the Strange Situation assessment respond either by getting angry (ambivalent-resistant) or displaying behaviours of helplessness (ambivalent-passive) upon being reunited with their caregiver (Crittenden, 1999). These behaviours are

suggested to be a conditional strategy adopted by the child to maintain the caregiver's attention, with the intention of trying to control the interaction because these interactions are regularly out of their control. An infant forms an insecure anxious-avoidant pattern of attachment similarly to an ambivalent attachment where, because the caregiver provides inconsistent care, the child cannot maintain an attuned relationship with them. The infant then comes to believe that their emotional wants are not able to be communicated to their caregiver and they have no ability to influence them. The anxious-avoidant pattern of attachment presented in the Strange Situation assessment within children who often looked unphased by the caregiver's disappearance or by them remerging. They showed calm, unflappable behaviour, but it was theorised that they were deeply distressed. This was corroborated when they recorded the heart-rates of the infants which showed patterns of distress (Ainsworth & Bell, 1970; Sroufe & Waters, 1977).

The last of the insecure attachment styles is one that is linked with abuse, neglect or significant trauma, named disorganised attachment. It was first identified because there were unusual behaviours that did not fit into the three prior categories (Ainsworth, Blehar, Waters, & Wall, 2015; Reijman, Foster, & Duschinsky, 2018). Disorganised attachment does not have one unified behaviour pattern that signifies it; more commonly it is characterised by seemingly inconsistent behaviours. Infants can seem disorientated, confused, dazed, performing contradictory or jerky behaviours and can show signs of dissociation (Ainsworth et al., 2015). Ainsworth et al. (2015) propounded that this attachment style is in response to having a parent that was insensitive, unpredictable, and abusive, and the infant has no organised strategy to deal with it. The child was not soothed by its parents or cared for in a loving and an attuned way. When there are reports or evidence of abuse in any form towards a child, there is need for placement into emergency respite or foster care, which can happen rapidly. For children who are removed from their families and placed into foster care through child welfare services, the

transitions are understandably difficult and stressful for many children (Mennen & O'Keefe, 2005). For a child who has been abused there are many different ways their brain can adapt and learn to respond to it, as put forth by the Neurosequential Model of Therapeutics and the theory of latent vulnerability, which will be discussed in more depth below (McCrory & Viding, 2015; Perry & Hambrick, 2008). The parenting of these children makes it more likely that they experience maladaptive development, resulting in them having insecure or disorganized attachments or more severe attachment disorders. Such children develop maladaptive internal representations of being parented and nurtured. Many such children are 'primed for insecurity', such that they interpret any extended separations from their parents or caregivers as a catastrophic loss, and/or as evidence that they are inherently bad and unlovable children (Tarren-Sweeney, 2016; Tarren-Sweeney & Goemans, 2019).

In the context of this study, attachment theory must be considered because the causational factor for many of the children to go into respite care centres is the parents having limited parenting skills and availability for their children (Aldridge, 2006; Donald & Jureidini, 2004). This relates to how insecure attachments are formed because when a parent is not attuned to their baby's needs, it is often due to limited parenting skills or capacity, which, in the extreme end, can be abusive and result in the child being placed in foster care (Aldridge, 2006; Baer & Martinez, 2006; Donald & Jureidini, 2004; Gordon, 2003). With this understanding it could indicate a potentially high correlation between respite care use and insecure attachments. Parents that create insecure attachments with their child during infancy thus struggle with harder to manage behaviours in their child's later development. As the attachment relationships persist into childhood, the internal working models that were programmed through the two-way, mutually-reinforcing process can exacerbate behavioural difficulties (Rees, 2007).

One suggestion as to why this occurs is that it is a self-perpetuating cycle: the parents' poor treatment of the child results in the child's difficult behaviour, which is then poorly addressed by the parents and the cycle continues. On the other hand, children with secure attachments are happier and easier to care for, which develops a healthy cycle between parent and child. The anxious-ambivalent child tends to be whiny and clingy, and the anxious-avoidant child is distant and prone to bullying, both of which often elicit unfavourable responses from their caregivers (Bowlby, 2005, p. 143). These behaviours perpetuate a vicious cycle between parent and child where their response to the behaviours results in continued difficulties in the attachment. The children's socio-emotional development due to their attachment can be affected drastically; there is a direct correlation between insecure attachment and displaying a high frequency of externalising behaviours, depression, anxiety, and difficulty regulating emotion and interacting competently with peers (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010; Kerns & Brumariu, 2014; Khan, Fraley, Young, & Hankin, 2020). The association between depression and insecure attachment was examined in a recent longitudinal cohort study, which found a relationship between higher levels of attachment anxiety and avoidance with increased levels of depressive symptoms (Khan et al., 2020). The author does not suggest that attachment is solely responsible for all behavioural difficulties and poor internal beliefs; there are other factors at play that severely affect development, which will be discussed; however, attachment does play a significant role. With the heightened likelihood of behavioural difficulties for insecurely attached children, parents who were ill-equipped to form a secure attachment with their infants become increasingly unable to deal with their children as they grow.

Parents of children who have regular externalising behaviours are often recommended respite care as a course of action (O'Connor & Zeanah, 2003). O'Connor and Zeanah (2003) suggested, however, that this might have ramifications due to the already compromised

attachment between parent/caregiver and child, depending on their age, physically or developmentally. They continue by saying that, because of the "poor attachment experiences," the insecurely attached children "would be the least able to cope with repeated separations" (O'Connor & Zeanah, 2003, p. 240). Separation anxiety is a safety mechanism that humans have because it signifies an increase in danger; for children who cannot care for themselves or who depend on an individual, the threat of abandonment can be terrifying and scary (Bowlby, 2005). It is suggested that the threat of abandonment is one of the causes for the most intensive forms of separation anxiety. If being put into respite care is used as a threat by parents so that a child will behave at home and then the child (as a result of poor behaviour) is consequently sent to respite care, the abandonment that they may feel could aggravate an already insecure attachment with that parent/caregiver. Using respite care as a consequence for 'bad behaviour' therefore undermines the many potential benefits it can have, such as giving the parent/caregiver a break and thus helping them to parent better; instead, it may have a paradoxical effect of causing the child to go through separation anxiety, which may have impacts long term on their attachment (Howe, 1999).

Another possible consideration is that the child's attachment relationship could result in the child experiencing parentification (Hooper, 2007). "Parentification in the family entails a functional and/or emotional role reversal in which the child sacrifices his or her own needs for attention, comfort, and guidance in order to accommodate and care for logistical or emotional needs of the parent." (Chase, 1999, p. 5). This is in part due to the lack of involvement with peers, as a result of their heightened responsibility to care for their family. This is an effect which can be explained by attachment theory, which examines the parent-child dyad as a child's basis of their own internal working model. Children who develop role-reversal are at risk of poorer outcomes during their development, including poor peer relationships, attachment disorders, and poor self-identity from family (Hooper, 2007).

Social learning theory and social cognition

Social learning theory and social cognition must be considered when contemplating how children experience and perceive going into respite care. It has been theorised that the learning process that informs an individual's social behaviour is directly linked to their observations of the social behaviour of others, meaning that a child will observe others' behaviours and then imitate what they have seen (Bandura & McClelland, 1977; Tory Higgins, 2000). Social learning theory puts forth the idea that learning is a cognitive process that occurs in a social context and people can learn through observing someone or via direct instruction, without motor reproduction or direct reinforcement (Bandura & Walters, 1963). In the case of children in respite care, children learn from, and respond to, what other people say and do, and they learn from observation, particularly of their parents. According to social learning theory, processes that occur regularly and within daily social interactions provide ample opportunity to exert themselves upon an individual as a learned behaviour (Snyder, Reid, & Patterson, 2003). Due to this, social relationships provide consistent and recurring learning experiences. It is also well understood that these learned behaviours are not solitarily selective to positive behaviours, only whatever is being modelled to the individual, which can often include antisocial or oppositional behaviours (Snyder et al., 2003). Parenting techniques that incorporate social learning theory–based interventions find that the behaviours of the children become easier to manage and this increases relationship quality (O'Connor, Matias, Futh, Tantam, & Scott, 2013). For other families where these behaviours cannot be managed due to a number of different reasons, respite care can be suggested (Karnik, McMullin, & Steiner, 2006; Steiner & Remsing, 2007).

Children learn and are taught behaviours from the environment around them (Bandura & McClelland, 1977). Bandura and McClelland (1977) discuss the two types of reinforcement: direct and vicarious. The latter is relating to those who observe a situation from the outside and

learn the response appropriate to the situation even though the observer is not directly being reinforced. In their study they discuss that those who observe a situation can often learn more rapidly than those who the reinforcement is being used upon. In the current study, both direct and vicarious reinforcement could relate to children who are sent into respite care by their parents/caregivers/guardians, through the way the parents speak about the reasons that they are sent into respite care. This could also be reinforced by the way staff or other children speak about respite care in front of them. For example, if a child is told by a parent that they are sent into respite care due to their own anger management issues, then that is reinforcing that belief that they are the reason for being sent there. If the child then says to other children why they are there, then it might vicariously reinforce to other children that it is a place for children with anger issues or other behavioural issues. Vicarious reinforcement would also apply in the case of a child listening to a parent talk to a sibling about why they are being sent into respite care.

Both direct and vicarious reinforcement may occur while the child attends respite care in constructive ways, such as the way helpful behaviours are modelled to them through staff interactions. Due to the number of vulnerable children who attend such facilities who may not have positive role-models, respite care stays might reinforce positive behaviours. Acting as a social learning environment, respite care could act as a staging area for children to learn social cues from caring and attuned staff. This social reinforcement is dependent on the facility employing positive behavioural approaches in their practices. If this is the case, then children would be able to watch the staff interact with other children to observe and learn how best to interact with others, and they can also observe the interactions made towards them from staff, allowing for both vicarious and direct reinforcement. Not only are positive behaviours able to be reinforced through direct and vicarious learning but so are negative ones. There is evidence to suggest within a social learning framework, that there can be negative outcomes for children

who develop friendships with peers who are deviant, conflictual or have adjustment problems (Vitaro, Boivin, & Bukowski, 2009).

Social cognition suggests that learning is used to "regulate feelings and thoughts as well as action, and humans are 'watchers' and 'listeners', as well as 'doers'" (Tory Higgins, 2000, p. 5). That learning is partially in response to personal interactions with the world, but also in response to observing others and their decisions, and the consequences of those actions, to then inform personal choices. This can often come from others' instructions or communication with others around the individual, showing the importance of listening to others and learning from them (Fiske, 1993; Fiske & Taylor, 1991; Tory Higgins, 2000). Tory Higgins (2000) discusses how, for social cognition, there are some distinguishing properties that individuals who are observing others try to learn about others' underlying intentions. In particular, an individual observer who is concerned about the dynamics between themselves and another person and their viewpoints, can go as far as being motivated to "construct a shared viewpoint with their target" (Tory Higgins, 2000). For children who are learning from their parents and are attending respite care facilities, their own viewpoint of the situation might be influenced by that of their parents. This could then be consequently impacting the child's own socially learned perception or belief about the facility or about themselves. These learned behaviours, responses, and viewpoints are all coded into their own memory and can be drawn upon later in other situations that activate such categories (Fiske, 1993; Fiske & Taylor, 1991; Tory Higgins, 2000). With this in mind, the child's experience may be influenced by the shared viewpoint that they have constructed of the situation. These learned viewpoints may be positive or negative, influenced by what their parents'/caregivers'/guardians' viewpoints are or because of the way the children are spoken about. It is well understood by social theories that all individuals need to be able to understand how and why significant others in their lives respond the way they do to each other (Tory Higgins, 2000). From this, they infer those persons'

attitudes and preferences and learn for future interactions and observations what actions are congruent and discrepant from them to then rebalance their analysis of that person.

Causal attribution is often discussed in social cognition, and it suggests that people make causal inferences to attempt to understand possible reactions. At this stage individuals are analysing behaviours to determine if other responses to situations are from their personal or situational attributions. Thus, in doing so, the person who is making the causal inferences can determine causal attributions about the person (Fiske, 1993; Tory Higgins, 2000). For example, teaching a child to attribute their failures — where applicable — to their lack of effort, rather than to inherent faults or inability, causes their future performance to increase (Tory Higgins, 2000). If this is the case, then for the current topic this could have a significant impact regarding the way that parents address their children and how they talk about using respite care. It must be considered what the impact would be if children are attributing their anger or behavioural problems (rather than other situational factors) as being the sole reason for their stay.

Theory of latent vulnerability and Neurosequential Model of Therapeutics

As discussed previously, respite care is used in a multitude of different scenarios, including for those who are deemed ‘high risk’. These children who are deemed ‘high risk’ may have very capable parents who are highly stressed, or they may come from families of abuse; it varies from case to case, but overall, the children are at ‘high risk’ of possibly being neglected or abused, whether intentionally or not. The understanding of trauma and the ways it can present has been greatly expanded by researchers in the last thirty years, showing the lasting effects on a child’s development that it can have (McCrory & Viding, 2015; Palacios et al., 2019; Perry & Hambrick, 2008). Neglect and maltreatment of a child at any stage can have lasting effects as Palacios et al. discuss (2019) with the assertion that the maltreatment of a

developing foetus, infant or child can hinder the healthy developmental trajectory of that individual. If one is to consider the many sensitive periods of growth that occur during these early years of life, a disruption can cause a torrent of difficulties regarding the child's physical, neurobiological, cognitive and socioemotional processes (Palacios et al., 2019). This is due to the neurons that are uniquely designed to be responsive to changes in the environment in a 'use it or lose it' fashion. Abusive situations can incite chaotic patterns to emerge, which causes the dysfunctional organisation of the child's brain (Perry & Hambrick, 2008). This not only persists through childhood but can endure the life span, increasing the risk of psychiatric disorders and the severity of them (McCrory & Viding, 2015).

When children experience trauma of any kind there are many services that are offered to support them and their families, including respite care (Curtis, Foster, Mitchell, & Van, 2016; Perry, 2003). Respite care is a useful tool when a child has gone through a traumatic event, as there are indications that these children could present with oppositional behaviour or dysregulated emotion as they age because of this trauma (Ford, 2002; Palacios et al., 2019). This can provide parents/caregivers/guardians a break from the burden of care introduced by the trauma, which manifests itself in externalizing and internalizing behaviours.

Latent vulnerability theory puts forth the idea that a child's brain makes neurocognitive adaptions in response to early adverse environments (McCrory & Viding, 2015). These early adaptions are made by the brain to give the infant/child the best chance of survival. McCrory and Viding (2015) discuss the example of heightened neurocognitive vigilance to threat, which is first developed as an adaptive response in infants/children to an early chaotic, high risk environment. It, however, becomes maladaptive because the constant vigilance forms neural pathways that instantiate vulnerability to psychiatric disorders such as depression, anxiety, borderline personality disorder, and schizophrenia, along with higher susceptibility to poorer physical health (McCrory & Viding, 2015). The lasting effects of maltreatment go on to alter

the functioning of the individual to such a significant degree that it can have wide ranging effects across the entire lifespan. Children's behaviours, as discussed in chapters previous, are largely influenced by their relationship with their parents and the social world around them as they grow, and latent vulnerability expands deeper into the understanding of the development of the child.

The Neurosequential Model of Therapeutics has a similar lens to latent vulnerability, discussing how, due to the sequential development of the brain, missing a significant milestone gives rise to complications during the development of later stages (Perry, 2003; Perry & Hambrick, 2008). The model shows, however, that children who miss critical stages of a healthy early development due to maltreatment or neglect can slowly be reintroduced to them though repetitive experiences that activate the area in question that is underdeveloped. The method of doing so is to identify the areas in question and design activities or situations that will repeatedly activate them, so that the neurons can reorganise themselves into functional patterns. The consistency of an attuned caregiver, for example, would contribute to this process. The importance of taking a neurosequential perspective, in regards to respite care, is that for caregivers of maltreated children respite care helps "to promote effective and optimal opportunities for a healing environment." (Perry, 2003, p. 20). The setting — if constructive in every way — would therefore promote and foster the active reparation of underdeveloped areas for traumatised children. This also aligns with what was discussed previously, in that respite care provides caregivers the opportunity to be best equipped — with rest that enables them to continue providing care to these high-risk children. If, however, adverse perceptions or experiences of respite care are a reality for a traumatised child, the repetition of attending may possibly reinforce negative patterns of self-belief or further their trauma. This is an important consideration because when a child has suffered from maltreatment, there is a heightened probability of behavioural disorders, which then increase the burden of care associated with

the child (Ford, 2002; Kefeli et al., 2018; Palacios et al., 2019; Taillieu et al., 2016; Tarren-Sweeney, 2016) Children who exhibit high behavioural needs then have an increased likelihood to attend respite (O'Brien, 2001). Therefore, it is easy to perceive the correlation between abuse and a high number of respite care placements, making the above considerations particularly pertinent.

With the understanding of latent vulnerability and the approach of The Neurosequential Model of Therapeutics, a further important consideration must be how traumatic events can also be those that come in the form of an accident such as a car crash or an environmental disaster such as an earthquake. In the South Island of New Zealand, where the current study is being conducted, two areas have been heavily affected by earthquakes, Christchurch (2010-2011) and Kaikōura (2016). Research indicates that natural disasters of this kind lead to a significant population decrease, which happened in these areas as families moved to different cities and towns (Love, 2011). This means that the affected groups of these disasters will be widespread. There is evidence to suggest that there are increased levels of behaviour problems and post-traumatic stress symptoms when comparing pre and post-earthquake groups starting school (Liberty, Tarren-Sweeney, Macfarlane, Basu, & Reid, 2016). Christchurch also suffered a mass shooting in 2019, which could result in children being traumatised and possibly having long-lasting implications (Bonanno, McConnaughey, & Mincin, 2021; Daniels & Hyatt, 2018). With the current state of the world, the effects of the COVID-19 pandemic also need to be contemplated with at-risk families. The stress that the pandemic has placed on some families is significant and has been attributed to a decline in mental health: “Analyses revealed significant associations between parent COVID-19 pandemic stress, parent depression, anxiety and stress symptoms, and increases in child internalizing and externalizing problems.” (Whittle, Bray, Lin, & Schwartz, 2020, p. 3). These events are important considerations as it may affect the developmental trajectory of the children in the South Island region.

In summary, The Neurosequential Model of Therapeutics and the theory of latent vulnerability are important developmental theories to understand when talking about children in respite care because of the significant proportion of these children who have experienced trauma (Thoburn, 2020). As discussed above in relation to the theories, repetitive and consistent activations of an area in the brain can result in the neurological clusters to rewrite themselves — either positively, as a form of therapy, or potentially as further perpetuation of negative self-beliefs and dysfunctional development. Holding this in mind, when a child consistently visits respite care or is privy to discussions about why they are being sent there, it could have lasting imprints in the child's brain development. How respite care could help or hinder the developmental processes is not the purpose of this study and it does not intend to answer this question, but the ramifications of such must be contemplated.

Part 3: Rationale for present study

The overwhelming majority of studies in this field have considered the parents/caregivers/guardians as the primary beneficiaries of this intervention but have neglected to investigate the effects that this support service has on children who have been sent into respite care. The few studies that have considered the child's perspective are, more frequently than not, considering it from the perspective of children who are on the extreme end of care needs, having multiple significant impairments, physically or intellectually (Minkes et al., 1994; Stewart, 2017; Uhrman et al., 2019). It is true that, within New Zealand, respite care provided by the Ministry of Health is most commonly in the sector of elderly care or children who have significant physical disabilities or other disabilities such as Autism Spectrum Disorder (Ministry of Health NZ, 2020). However, not all children who are sent into respite care in New Zealand are significantly impaired to that extent; there are respite care centres or respite camps that are used to support parents and caregivers of children within

normal behavioural parameters or children who have lesser complex needs (Barnardos Temporary Family Care, 2021; "Cholmondeley Children's Centre," 2020; STAND Tū Māia, 2021). With so few studies conducted in this area, there has been an assumption made that, by giving caregivers relief from their duty of care, the benefits of this will offset any negative effects, without inquiry as to what those could be. While this cannot just be assumed, it is, however, an area for further investigation.

When broadening the scope to encompass all literature investigating respite care, the current study concluded that a plethora of studies have investigated this intervention but all were predominantly from the perspective of the parent/caregiver. Yet the understanding of children's experiences and perceptions of respite care cannot be forgotten and has been woefully underexplored (Schroder et al., 2014). It is vital to the grasp how children conceptualise this experience and perceive their stays at such places. Thus, a clear gap in the literature has been found, indicating the need for exploration into this field. The study conducted by Read (2008) highlights the importance of the current study, as it suggests that within New Zealand there are children who have negative experiences of respite care. If children do not want to go into respite care, then their time there may be impacted by, and marked with, negative experiences or beliefs. The author of the study suggested that a future avenue of research would be to investigate children and their response to being separated from their primary parent during respite care (Read, 2008). Schroder et al. (2014) (in studying a similar population group) acknowledged that, while there were benefits for children in respite care, there were potential risks and pitfalls associated with respite care if children believed that they were the problem. Conversely, there are findings of children who have attended respite care camps and reported feelings of increased relatedness through friendship, autonomy, and/or increased self-esteem while they there (Stewart, 2017; Uhrman et al., 2019). Both of these studies' primary populations were children who were disabled; however, there may also be

some overlap of relevance to the current study, so questions relating to these areas were considered during the selection of the method of data gathering.

There is clear understanding in the literature about how the effects of parenting can impact the child's development negatively through maltreatment or the lack of parenting skills (Baer & Martinez, 2006; Carnochan et al., 2013; Cashmore, 2014; Chan & Sigafoos, 2001; Cooper, 2014; Cowen & Reed, 2002; Crittenden, 1999; Curtis et al., 2016; Day et al., 2018; K. L. Drake & Ginsburg, 2012; Eaton, 2008; Farc et al., 2008; Fearon et al., 2010; Ford, 2002; Garbarino, 1976; George, Herman, & Ostrander, 2006; Glascoe & Leew, 2010; Kerns & Brumariu, 2014; Kissman, 1999; Madden et al., 2016; McCrory & Viding, 2015; Perry, 2003; Tarren-Sweeney, 2016; Webster-Stratton & Herman, 2008). To help give every child the best chance of developing within the normal parameters, some parents who are identified (often through government agencies or self-referral) are given support. The support differs from case to case and depends on the family's situation, but respite care is one form of support provided. Around New Zealand, facilities have been built and organisations established which excel in offering respite care for children of families eligible for this type of support. Another provision offered to families in need of support for their tamariki (children) is respite camp. These camps are particularly for vulnerable children who are in situations and environments that pose a significant risk of harm to their well-being, as well as children with complex needs (STAND Tū Māia, 2021). Respite care can be offered at short notice to whānau (family) in stress or crisis, or as a planned stay or camp, allowing in either circumstance for a greater focus on well-being for both the child and family ("Cholmondeley Children's Centre," 2020). There are many organisations around the South Island of New Zealand that provide respite care for disadvantaged families in situations that require support. This is important within New Zealand as the ("Care of Children Act," 2004) gives a legal precedent that the welfare and best interests of our tamariki are considered, giving credence to current study's inquiry into what the

children's experiences and perceptions are of a facility/camp that they attend for large portions of their time.

This is not just specific to New Zealand but countries around the globe that also use respite care as a means of supporting families. Within the developed nations, certain subpopulations are over-represented in the areas of respite care: First Nation peoples in North America, African-American children in the United States of America, Aboriginal children in Australia, and Māori in New Zealand (Cashmore, 2014). The theory as to why this is occurring is the "poverty, dispossession, the fragmentation of traditional familial structures, and the high incidence of substance abuse and domestic violence, together with differences in the way they are treated by the child welfare systems and a lack of services in those communities" (Cashmore, 2014, p. 316). The disparity between Māori and non-Māori within New Zealand who are using respite care is an important issue, especially when considering the Treaty of Waitangi and how it calls for the equality between Māori and non-Māori. Longstanding neglect of this principle now calls for equity (Treaty of Waitangi [English version], 1840; Treaty of Waitangi [Translation of Māori version], 1840). Respite care is birthed from a western concept, as recounted in the historical summary in Chapter one. Therefore, as a colonized nation bound by The Treaty of Waitangi which states that Māori have protection of their cultural knowledge and values (mātauranga), it is paramount that New Zealand fulfils its obligation to consider Māori perspectives and experiences of respite care — especially given that Māori families are disproportionately represented in respite care services (Ministry of Health NZ, 2018a).

Respite care facilities and organisations do not fit into a universal model of respite because there is no such standard (Pollock et al., 2001). Similar occurrences do happen, however, such as in the common case of children being placed in these facilities due to the needs of their parents — because they are, for instance, under severe stress or lack the necessary skill set or capacity to care for their child(ren) without support.

The way parents/guardians/caregivers voice their frustration and criticise their children can have enduring negative effects on them (George et al., 2006; Webster-Stratton & Herman, 2008). As the child matures, this can leave an impression on the child's psychological development with regards to internalizing symptoms and negative self-beliefs. Other developmental factors such as low parenting competence, which is unpredictable, critical, inconsistent, noncontingent, nonnurturing and hostile in nature, can leave lasting impressions on the child (Webster-Stratton & Herman, 2008). Speaking critically about a child can have permanent consequences on the child and their view of themselves. It can seep into the child's self-beliefs and their opinion about the world around them (Webster-Stratton & Herman, 2008).

The normal rationale for implementing any form of respite care is the burden of care being significantly high; however, as discussed previously, this is not always the case. Respite care can also be used to support socially disadvantaged families who may suffer in a range of ways, such as severe stress, poor health, or a lack of parenting skills and/or capacity necessary to parent effectively (O'Brien, 2001). As stated earlier, 'high risk' parents are more likely to perceive poorer behaviour in their children even when there is no clear behaviours that distinguish them from another child (Farc et al., 2008; O'Brien, 2001) These high risk, disadvantaged parents are unable to parent properly and consequently may perceive greater problems and/or cause their child to develop maladaptive behaviours and/or beliefs (Kissman, 1999; Team et al., 2020). This problem could be furthered by the way the child observes their parents sending them to respite care, especially if this happens along with criticisms made about the child's behaviour**.** It must be investigated then whether the parents of children who attend respite care use it as a way to criticise their children, which in turn might harm the development of their self-beliefs and self-esteem (Webster-Stratton & Herman, 2008).

There is almost an expectation that respite care is always beneficial for the child because of the reported positive influences it has on parenting, as discussed by numerous

researchers (Day et al., 2018; Harper et al., 2013; Jeon et al., 2005; Madden et al., 2016; Piescher et al., 2008; Pollock et al., 2001; Strunk, 2010). However, few studies have addressed the question of what benefits the children gain, except the value of rested parents/caregivers/ guardians. The actual perspectives and experiences of children within respite care has been rarely investigated, and studies which have been conducted are frequently aimed at children in residential care who are either severely intellectually disabled or in foster care (Minkes et al., 1994; Stewart, 2017). There is also discussion amongst authors about the reliability of the measures used to gather the information within these studies, and there is a limited number of empirical studies conducted in this area (Jeon et al., 2005; Pollock et al., 2001; Strunk, 2010). Pollock et al. (2001) discusses that, while there is no one unified model of respite care, qualitative evidence suggests that it works. They go on to say that rigorous and methodologically sound empirical studies are needed. It was out of the scope of this study to address this, but it is an important facet of the current understanding of respite care to note. For this study, a randomized control trial would not have been an appropriate methodology, but the author recognises that this is a significant limitation of the current study and in the field as a whole.

The author of the current study chose to investigate what the children's reports of respite care were, to provide information on the subject which might make conducting a quantitative study easier, or to stimulate questions that have not been asked before. This idea draws from Minkes et al. (1994) who discussed the value of creating a flexible interviewing method that allows any child to share and speak about their experiences while in respite care. The acknowledgement needs to be made that these children who are attending respite care are the ones experiencing and perceiving their stays; thus, parents, staff, and researchers cannot decide for them how they feel about it. The lack of research on the children's perceptions is surprising, especially due to the understanding that researchers have of the importance of

children participating in the development of their future in other areas (Bessell, 2011; Hart, 2013). Children who can be active in their environment and participate in decision-making feel more in control of their own lives. Children's participation can be separated into six levels, with each of the levels increasing the voice that the child has (Vis & Thomas, 2009):

1. The child is consulted but given no understanding.
1. The child is consulted but given no understanding.
2. The child is told information without a chance to convey their own views.
3. The child voices their views but does not participate in decision-making.
4. The child participates in decision-making but not in any independent decisions.
5. The child makes independent decisions but does not define the problem.
6. The child identifies the problem and makes the decision.

Vis & Thomas (2009) discuss how, at level 3 or above, a child is able to engage in healthy participation, provided their voice is actively considered and can influence the choices made by adults. In the case of respite care, there are obviously external factors that are important to consider, and the child cannot have complete autonomy in their choice to attend, especially if their stays could protect them from maltreatment. This does not discredit their voice entirely and the importance of their voice is still needed to determine how they internalize why they are being sent and how best to cater to each child's individual needs when in the care of such facilities. Within New Zealand, the Children's Care Act 2004 calls for the importance of the child's best interest being upheld, and this is an echo of the United Nations Children's Emergency Fund Convention on the Rights of the Child. Article 12 (1) states: "Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child" (The United Nations, 1989, p. 4). This supports the notion that the tamariki being sent into respite care have a right to voice their

views and share their experiences. The limited literature on the topic shows varying results on children's perceptions of respite, giving the present study cause for investigation.

Also considering the arguments made previously in the sections covering attachment theory, social learning theory, social cognition theory, latent vulnerability, and the Neurosequential Model of Therapeutics, with regards to how these approaches understand children's development, there is a clear precedent that attending respite care could pose a potential negative effect in a multitude of ways for these children. This study is not setting out to discredit or call into question respite care centres and the services they provide. The research question is only attempting to shed light on what else might be occurring when children attend such facilities. The importance of the child's voice cannot be understated.

CHAPTER 3

Methods

Research question

The present study was designed to explore the following research question:

How do children perceive and experience short-term respite care provided as a support intervention for families with parenting difficulties?

The present study conducted a qualitative study that aimed to address the research question by interviewing children from disadvantaged families attending a South Island–based respite care organisation (SIRCO), and report on their perceptions and experiences of attending such a facility. During the interview, the researcher asked questions and listened to the child's explanation of their experiences and their ideas about their stays. The choice to conduct qualitative research was so that the children's accounts of their beliefs, experiences and perceptions would be represented purely by the children's own words. By doing so, it allowed for the children to indicate if there were areas that they felt well supported in and other areas that they did not, which could warrant further investigation.

Design

This research question could have been investigated with a number of different methods, such as a quantitative design that uses self-report measures, or a qualitative design that draws from a formally administered questionnaire or qualitative interviews. Due to the lack of any research on this topic, it is preferable that the initial study be qualitative since there is not yet enough knowledge on the subject to design a survey questionnaire. With the intention of keeping the authenticity of the participants words and experiences accurate, five qualitative methodologies were considered: Case Study, Ethnography, Grounded Theory, Narrative

Analysis, and Interpretative Phenomenological Analysis. Considerations were made because of the age and vulnerability of the population being investigated; peer-reviewed articles and the criticism of each methodology were also considered. Individual oral interviews were selected as the information-gathering tool best suited to gathering data in this setting. The rationale behind this selection was due to the age of the participants, which meant their ability to read and write would be inconsistent and thus a potential limitation to reliable data. There was also the consideration that because there had been no study conducted in this area before, there was no self-report measure or written questionnaire in existence that would fairly quantify or ask what would be relevant to these children. In this way the study adopted an exploratory study design, intending to be broad enough for the children's perceptions and experiences to be recorded and kept authentic to their meaning. It is important to note that even though the children are young, there are indications in the literature that suggest that interviewing children is still a reliable method of evidence gathering (Heilmann, DeBrock, & Riley-Tillman, 2013). With these at the forefront of the study's aims, the selection of the methodology was conducted by a vigorous investigation of the methodological literature available.

Potential methodology 1: Case study

Case Study methodology was considered briefly, but as there were ample available participants at the SIRCO and the subject area was devoid of other research it would be too narrow a focus to only investigate and analyse a single case.

Potential methodology 2: Ethnography

Ethnography, as a qualitative design, met some of the requirements of this study. This methodology emphasised social interactions, behaviours, and perceptions that occur within groups; it adopts this view from an anthropological background and allows for rich holistic insights into people's views and actions from this perspective (Reeves, Kuper, & Hodges,

2008). This is conducted through detailed observations and interviews. Ultimately, this methodology was not selected on the grounds that it incorporated gathering information and observing situations from many different places. There had also been criticism directed at ethnography studies for observing situations through an anthropological or sociological theory lens and, thus, conclusions reached could digress from the true meaning of the participants' words (Hammersley, 2019). With this study intending to give a voice to children who have not had a voice before in this area, this was deemed not a useful methodology.

Potential methodology 3: Narrative analysis

Narrative analysis approaches a research question by listening to and exploring the experiences of their participants (De Fina & Georgakopoulou, 2019). This is a methodology that aligns with the goals of the study. However, the methodology focuses on the way in which people tell their stories by interpreting the words that are used to give rise to grander narratives within their speech (De Fina & Georgakopoulou, 2019). The constructivist role of language used in this methodology went beyond what was required for this study. As there was no current literature in this area, the individual perceptions and experiences needed to be retained, rather than interpreted expressions of those experiences.

Potential methodology 4: Grounded theory

Grounded theory is a methodology that is in itself a mix of flexible methodological strategies and also the product of inquiry (Bryant & Charmaz, 2007). In essence the theory boils down to six points as Bernard and Bernard (2013) explain:

1. Gather transcripts from interviews. Read thoroughly through a small sample of text.

2. Identify potential analytic categories from the transcript.

3. As categories begin to be observable, begin to compare them.

4. Contemplate the categories and their connection with one another.

5. Use the possible interactions between categories to inform the building of theoretical models. Check these against the data and carefully examine the negative cases in each instance.

6. Present the results of the analysis with the use of quotes directly from the interview itself to demonstrate the theory at work.

Allowing the data present to inform the categories is a clear strength of grounded theory. For this study, it would allow for the participants to speak about their perceptions and experiences at the SIRCO, and then from that, analysis could be formed to generate the data. As the participants words would directly inform the categories that arose from such analysis, it would keep the children's perspectives intact. This was a strong desire of the research — that the data collected would reflect the words and the voices of the participants. This methodology however, also brought with it some complications, because of which, this study opted not to use grounded theory as its main methodology. One of the main reasons was that the average number of participants that grounded theory required to interview was between 25 and 30, which created a timeframe issue (Thomson, 2010). The length of time it would take to recruit that many participants, conduct interviews, and follow the steps of grounded theory would take longer than the timeframe that this thesis was working within. Using grounded theory would then likely result in a rushed analysis of the categories and cause the exploration of the data to be significantly limited. Furthermore, COVID-19 brought additional limitations with it.

There were also a few other concerns that were raised by Olesen et al. (2010) against grounded theory; they suggested that with all the data generated by this methodology it was easy to be overwhelmed as a novice researcher. Grounded theory additionally fails to recognize that the researcher is also a product of their reality and their interpretations can be ill-informed (Olesen, Bryant, & Charmaz, 2010; Thornberg, 2012). Despite these minor objections,

grounded theory's method of data analysis from interviews would be respectful and consistent with this study's aims. With the advantages and disadvantages in mind, the current study sought to use a methodology with a similar ability to explore the perceptions and experiences of the participants in abundant detail, whilst also having a clear and useable data collection and analysis method and a sample size that fit within the constraints of the timeframe.

Potential methodology 5: Interpretative phenomenological analysis

The final methodology investigated was interpretative phenomenological analysis (IPA), which is a qualitative research design. The theoretical basis of IPA is an idiographic mode of inquiry, focused largely on the meticulous analysis of individual cases (Smith & Shinebourne, 2012). IPA shares considerable amounts of its principles and procedures with that of grounded theory, but the two methodologies deviate at particular points, which allows IPA to fit with the aims of this study more readily (Smith & Shinebourne, 2012). Where IPA and grounded theory are similar is in systematic text analysis, which highlights themes and categories arising throughout the interviews. They differ in that IPA explores experiences while making no attempt to derive theory from the information gathered (Willig, 2013). It is an approach that is used with the understanding that the children being interviewed "are 'self-interpreting beings', which means that they are actively engaged in the events, objects and people in their lives" (Pietkiewicz & Smith, 2014, p. 8). With the children being recognised as such, their experiences and perceptions on respite care, shared during the interviews, would be protected and translate directly to the results of this study. IPA also fits well into this study's aims from a theoretical perspective as it is committed to the participant as a cognitive, linguistic, affective human, and it connects the participant's words with their emotional state (Smith & Shinebourne, 2012). By doing so, IPA is recognising the whole person as an individual, regarding highly what is discussed and attempting to honour the children and the statements they make, and the thoughts behind them, during the interview.

It is a participant-oriented approach which allows for the 'lived experiences' to be explored without any distortion, as it considers the participant as the experiential expert in their life (Alase, 2017). This is analysed in IPA, as Alase (2017) describes it, as words or statements made during the interview that all relate to the 'core essence' (central meaning) of that participant's 'lived experience' relating to the subject in question. They go on to say that the participant is trying to answer the question by conveying their 'lived experience' through their responses. IPA's basis for this approach is that people are often unable to articulate the way they truly think or the way they feel about situations, and that people can withhold information for a multitude of reasons (Smith & Shinebourne, 2012). Therefore, this methodology does not assume truthful answers, and so the researcher — while maintaining the 'core essence' of an interview — must interpret people's mental and emotional state during their analysis of the interviews. IPA also suits the timeframes of the thesis, as it requires a smaller sample size, suggested to be between 2-25 participants. An important note to make is that there is a sacrifice of breadth of participants for the depth of the interviewing process (Alase, 2017).

IPA also stresses the importance of rapport building during the data-gathering process, considering that the information gathered is strictly from the interviews, meaning, the participant sharing personal perspectives on topics is vital. Therefore, IPA considers the establishment of rapport between the interviewer and the interviewee of the utmost importance. This methodology encourages the practice of rapport building at the start of sessions so the participants can feel relaxed (Alase, 2017). In this specific study, the development of rapport had an advantageous head start as the researcher — having worked at the SIRCO the study was conducted at for the past five and a half years — had already formed a positive relationship with all the children who were being interviewed. Having rapport with the participants would allow the semi-structured interviews with the children to be as open and honest as possible, allowing the children to be able to share their lived experiences and their stories freely with

someone they already had a relationship with (Alase, 2017; Pietkiewicz & Smith, 2014; Smith & Shinebourne, 2012). Combining this with IPA's gold standard data collection method — semi-structured interviews — meant that the interview would follow the child's thoughts, and it would be their words not the researcher's assumptions (Alase, 2017; Pietkiewicz & Smith, 2014; Smith & Shinebourne, 2012). This enables the participant to answer the open-ended questions in the way that they see the world, with the researcher then following them into novel areas, producing rich data (Smith & Shinebourne, 2012). The IPA method also has the beneficial effect of reducing the preconceptions that might be evident within more structured questioning.

In summary, IPA has the strengths of grounded theory but also the ability to have a smaller participant pool, with a focus on their lived experience (McDonald, 2011). Thus IPA would allow the participants to express their thoughts and feelings on respite care, providing full, descriptive accounts of their experiences (Pietkiewicz & Smith, 2014). This investigation concluded that IPA would be the most appropriate methodology for this study.

Study setting

The current study conducted its investigation at a New Zealand–based respite care organisation who requested that their organisation be kept anonymous, due to the vulnerable families that they have attending. Children between the ages of 3-12 years old go to this facility for short-term, planned respite care and occasionally, in specific circumstances, for emergency respite.

Participants

A purposeful sampling method was used as recommended by the methodology of IPA (Alase, 2017; Smith & Shinebourne, 2012). All participants were recruited from a New Zealand

SIRCO, and an independent employee went through the database using a list of inclusion and exclusion criteria. To minimize bias and any conflict of interest (due to the researcher having a working contract with the SIRCO) the participants were identified and recruited by the independent staff member. These criteria were selected by consulting IPA recommendations, with an attempt to recruit a homogenous sample that represented the population under investigation. Children were selected based on age because, as the gold standard of IPA is semi-structured interviews, it was important that the children were old enough to understand the questions. Selection criteria for participation were that the children were between the ages of 8 to 12 and had a planned stay at the SIRCO during the interview phase. As suggested by Alase (2017), it was important to select participants that had similar lived experiences to each other, so inclusion criteria also extended to children who had at least two or more stays at the SIRCO in the past 12 months. Exclusion criteria included children residing in the statutory care of Oranga Tamariki (approval to interview these children would not be given within working timeframes) and children with an intellectual disability, as the interview has complex questions.

Prospective participants were identified and shortlisted according to the aforementioned criteria by the independent staff member using the SIRCO database, which they had legal permission to access through their staff contract. Of the participants who responded to the recruitment email, a selection of participants who represented a homogenous group from the SIRCO were selected. As (Alase, 2017) suggested in her study, a sample size of 2–25 participants was recommended; in the instance of this study the number was narrowed to between 8–10, which would be finalized depending on time constraints.

Procedure

As suggested by IPA guidelines, the participant group was intended to be a small homogenous sample of children that attend the SIRCO (Alase, 2017; Smith & Shinebourne,

2012). Due to the small sample size, random sampling would have not been appropriate, and instead a purposeful sampling method took place, as discussed.

After the children were selected by the independent employee from the inclusion and exclusion criteria, the names of the children were passed on to another staff member who had direct contact with each family. The parents or legal guardians of each of the children were sent an email (APPENDIX A) by this staff member. If the parents/caregivers/guardians agreed to allow their child to participate, then they replied to either the staff member's or the researcher's email provided. They were then sent an email from the researcher introducing themselves and providing the Information sheets and Assent and Consent forms (APPENDIX B, C, D, E). They were also asked for their child's stay date, age, gender, and ethnicity and were given the opportunity to ask any questions about the study via email or phone call. Depending on the situation for each family, the researcher either met with the family prior to the child's arrival or at the SIRCO at the beginning of their stay. The researcher met with the parent/ caregiver/guardian and child in a private room and went through the process of induction to the study; they also sought their verbal consent and their physical signing of the Assent and Consent forms. The participants were asked if they were okay with the interview taking place at a particular time during their stay and were allowed time to ask any questions.

On the day of their interview, the children were given reminders by staff that it would be happening so that they were not surprised by it. The researcher met with the children at the specified time — at lunchtime on the first day of their stay. As a form of rapport building, the children were invited to pick a game or two from the games cupboard that they wanted to play while being interviewed. They were asked if they wanted a support staff member (only one participant took up this offer) and then taken to a private but visible room. The researcher led the child through the Assent form once again and walked them through the Oral Briefing script (Appendix F.). The child was also shown how they could skip or stop a question by tapping

either of the post-it notes (titled ‘skip’ and ‘stop’ respectively) placed within their reach. After that, the interview officially began and the microphone was switched on. The first part of the interview revolved around building trust and rapport, so frequently it focused on playing the game which had been selected by the child. This period was not a set time but one that was gauged by the researcher. Once sufficient rapport had been built and the child seemed calm, the first question was posed. The semi-structured format meant that many questions were asked, and no two interviews were the same. The interview lasted between 25 and 40 minutes, with the average time being around 30 minutes, as recommended (Griffiths, 2009; Morison, Moir, & Kwansa, 2000). Once the interview was over, the researcher and the child put away the game they had played and said goodbye.

After the interview, the researcher was required — as stated in the Consent, Assent and Information forms provided to families — to report to the Practice Manager of the SIRCO anything the child said which could be considered as indicative of potential or real significant harm to themselves or others. A statement was written down and given to the SIRCO to assess and go through their official channels. This procedure was conducted following one of the eight interviews. The interview recordings were kept on a secure digital server, with access being in a locked room before being transcribed by the researcher and then subsequently destroyed.

Interview design and format

The interview was designed around the gold standard for the IPA method, which is a semi-structured interview (Pietkiewicz & Smith, 2014; Smith & Shinebourne, 2012). The idea is that, to analyse the perceptions and experiences of the participant, the data-collecting instrument must be flexible and not ridged. This is not the only method available to researchers using the IPA methodology but, in this circumstance, it was, as other forms required reading or writing which would be beyond the capabilities of the participants. This data collection

method, however, allows for a dialogue between researcher and participant to follow the natural path of the conversation and explore novel areas that arise.

Another design consideration was for the interview to factor in cultural considerations to best accommodate those participants of Māori heritage. This was of supreme importance due to the Treaty of Waitangi and the issue of Māori being over-represented among children in respite care (Cashmore, 2014). To do this, a Māori framework was adopted, based on the process of the traditional hui (gathering/meeting/conference). The hui process suggests four key elements of any consultation (Lacey, Huria, Beckert, Gilles, & Pitama, 2011).

The four elements are as follows:

- Mihi: Greeting and engagement (Introduction)
- Whakawhānaungatanga: Making a connection (Building rapport)
- Kaupapa: Attending to the main purpose of the encounter (Interviewing)
- Poroporoaki: Concluding the encounter (Finishing the interview)

This framework was instituted carefully into the interview design to incorporate culturally competent practices.

The mihi process was demonstrated firstly in the initial warm greeting of the child and their support person (if needed). It also included the researcher's invitation for the child to select a game to play during the interview. The principle of engagement, within the mihi element, was demonstrated through making sure the child was comfortable with everything in the Oral Briefing script and had the opportunity to ask questions. This led on to the child's engagement with the game, which also formed an important part of the whakawhānaungatanga process.

The whakawhānaungatanga process was not a set length of time — and was necessary to maintain throughout the interview — but in the initial stages of the interview especially, this

element was about establishing rapport, forming a connection, and helping the child to relax and engage. Therefore, the game was set up first and played until the researcher determined that positive rapport and engagement had been established (Saywitz, Lyon, & Goodman, 2017).

The Kaupapa section began after this, with the child being asked the opening question. There are only three set questions prewritten; these were broad enough to engage in topics about the child's experience of the SIRCO, yet conscious not to direct or bias them in any way. They are as follows:

Can you tell me a little bit about what it is like staying at [the SIRCO]?

Can you tell me a little bit about why you are staying at [the SIRCO]?

Can you tell me a little bit about what it is like to be at [the SIRCO] with the other kids?

The second and third question were used with the flexibility to be modified during the interview, depending on the direction that the interview took.

After the discussion with the child, there was a period for the Poroporoaki, which was the conclusion of the interview. In this time, the researcher checked that the child was okay with everything they had covered in the interview, and then they thanked and said goodbye to the child.

Interview transcription and data analysis

The assumption made when conducting a study within the IPA methodology is that the researcher is interested in learning about the respondent's psychological world, with the aim being to: "try to understand the content and complexity of those meanings rather than measure their frequency." (Smith & Shinebourne, 2012, p. 66). To do this, IPA requires a sustained engagement with the data; thus, a slow and methodical process of reading and rereading the transcripts occurred. This allowed for the researcher to engage in an interpretative relationship

with the text, with the intention that the narration of the research would be directly in line with that of the participants' 'lived experiences' (Alase, 2017). Smith and Shinebourne (2012) discuss the length of time needed to do this method and that the process is labour intensive and demanding. As discussed by Alase (2017) in their study, the analysis portion of the study can be broken down to three generic cycles, all of which require the researcher to read the transcript of the interview multiple times while highlighting phrases and statements.

First cycle (steps 1-4)

The first cycle of reading the transcript is to slowly code the lengthy and convoluted responses that the participant gives into understandable statements/sentences. This is to help the researcher make clear sense of what they are working with and make it manageable. This will also include highlighting key words and phrases that the participant uses and expresses repeatedly. Alase (2017) suggests that sometimes these key words or phrases that are collected within the first cycle can be alluding to the 'core essence' of the participants' 'lived experience', relating to the subject of the research question. The outline of what this looked like is below, with the left-hand margin of the transcript used for annotations (Smith & Shinebourne, 2012).

1. The researcher listened to the recording and formed a verbatim written transcript; the transcript was subsequently annotated, with long passages of text condensed (thereafter, the recording was destroyed).
2. The researcher reread the transcript, annotating other areas that stood out, highlighting repeated phrases, and condensing the text further.
3. The researcher conducted a detailed line by line linguistic reading. Notes along the margin were made.
4. The researcher conducted a second detailed line by line review, investigating semantic components of the transcript. Notes along the margin were made.

Second cycle (steps 5-6)

The second cycle then involves condensing the first generic statements and phrases into fewer words still, giving the researcher another opportunity to analyse the transcript. This distilling of the text is an important process, as it aids the extrapolation of the 'core essence' from the participants' words and phrases, to find their 'lived experience' within the subject-matter (Alase, 2017). The outcome of this is a form of thematic coding which breaks down the participants' answers while still embodying their 'lived experience' without distortion (Alase, 2017). Smith and Shinebourne (2012) describe this as an important part of analysing the interview, as it produces what they label as themes that emerge through the text. These emergent themes can then be connected with others that have been recorded throughout the analysis.

5. The researcher reviewed the notes made and began to condense statements and phrases and list themes that were expressed in the transcript.
6. Condensed phrases were listed on an electronic document, along with the themes that were expressed.

Third cycle (steps 7-8)

The third cycle is known as the category stage; this is where the researcher narrows down the phrases and emergent themes that the other cycles have produced and then encapsulates them into their 'core meaning'. By doing this the researcher can then separate them into a summary table and distinguish how they describe the participants' experiences of respite care. While these emergent themes are narrow and specific, they are still accurate to the statements made by the participants and are the essence of their words. "Utilizing the generic coding method allows the researcher to meticulously and methodologically break down the participants' responses without diminishing or misrepresenting the core meaning of their responses or 'lived experiences' " (Alase, 2016, p. 66).

7. The condensed phrases were narrowed to their ‘core meanings’ of one or two words and then contrasted and compared to see connections with other emergent themes/core meanings.
8. These ‘core meanings’ of one to two words were transferred to a summary table. The table was split into the categories that the ‘core meanings’ fell into, depending on their essence. The original quotes from the text were put in a column beside to show reference and support these emergent themes.

Integration of separate cases

After the completion of the cycles the same method was adopted for the next interview with the use of discernment to recognise similar patterns of themes but also with an expectation that the participant will have their own ‘lived experience’. This was done through respecting the convergences and divergences in the data by recognising the similarities but also the differences in the interviews (Smith & Shinebourne, 2012).

9. The researcher after completing the interviews analysis, merged the summary sheets to form a master document to display the emergent themes or ‘core essence’ alongside the direct quotes.
10. Convergences and divergences in the data were identified. Alongside this, under the same categories the individual participants parallels, and distinctions of their descriptions were noted.
11. The researcher went through the themes and ‘core essences’ so that the write up would clearly display the ‘lived experience’ that the participants discussed. The themes that were selected to discuss in the write up were prioritised with the relevance to the research question.

The outcome of the interviews and their analysis are explored in the results section.

Ethical considerations

There were several ethical considerations that needed to be accounted for in the design of the present study, particularly because the population under investigation was vulnerable children. The study was approved by the Human Ethics Committee at the University of Canterbury and the SIRCO's Board of Trustees (see Appendix G and H). There was no funding provided by any other institution. All interview transcripts in the results section are directly taken from interviews themselves.

Privacy and confidentiality

Privacy and the confidentiality of each participant was of the utmost importance because of the nature of the vulnerable children being interviewed and the facility's request to be anonymous. The study does not name the children or use pseudonyms. No child was specified when quoting something that they said, with every quote adjusted so that no details were left that made them identifiable. In the same way, the organisation requested that they be referred to as a South Island–based respite care organisation (SIRCO) to give them anonymity in the research, so any mention that could identify them has been removed. Steps were also taken, to the best of the researcher's ability, to give the children being interviewed anonymity from the staff and other children that were also staying/working at the time of the induction and interview. All information that was gathered was kept in a secure place within a locked room when not being analysed. Any digital files and the recorded interviews were protected online and have since been destroyed after the transcript was written. The only information that was not kept confidential was any information pertaining to significant harm or potential harm. Anything said during the interview that was within this spectrum was reported in the normal methods that the facility had. Besides information relating to risk of harm, no information was shared with the facility.

To ensure the confidentiality of the participant and what they had shared, the researcher also did not work on a shift with that child while the study was taking place and for 12 weeks afterward. In this way, confidentiality was ensured as any information about the child would be protected and would strictly be used for the study itself.

Conflict of interest

Due to the researcher being a staff member at the facility, this study recognises that there was a possible conflict of interest, as there was a potential for information gathered prior to the study (during shifts with children) to be used during the interview itself. This consideration was mitigated in several ways: firstly, by reducing the number of work hours prior to the interview phase, and throughout, to only two shifts every six weeks, so that the chance of working with children who could be involved with the study would be reduced. During the interview, the researcher attempted to only discuss what the participant or parent had discussed in the induction or interview itself; any information that was known previously was not spoken about unless brought up by the child themselves or parent/caregiver/guardian during the induction. Information from the induction included parents disclosing sensitive areas for their child that helped the researcher know to take care when/if covering those topics. This study recognises that conflicts of interest cannot be completely removed, which is further discussed in the limitations of the study.

Removing real or perceived pressure to participate

After the independent staff member selected the participants, their parents/caregivers/ guardians were emailed (see APPENDIX A), and this email was written alongside the University of Canterbury Human Ethics Committee and the Research Director of the SIRCO to ensure that it was worded in such a way that families would not feel pressured to participate. As can be seen in the email, it explains that it is voluntary and that there would be no ill effect

if they chose not to participate. If the parents/caregivers/guardians replied to this email or to the researcher themselves, a dialogue began between participant and researcher, with frequent reminders by the researcher that it was completely acceptable for them to drop out at any point. This was reiterated to the child so that they or their parents could stop at any time, with an understanding that there was no pressure to participate. Some children and their parents declined to participate after reading the email containing the information about the study. One participant, during the Oral Briefing script induction process, decided not to continue with the interview, and so they were told this was completely fine and the induction was immediately brought to a close. Another participant was later selected in their place. With all participants who did complete the study, opportunities were given before and during the interview for the child to stop at any time; this was explained in the Oral Briefing script (see APPENDIX F.), which was read to the child beforehand and reinforced with the placement of the 'Stop' and 'Skip' pieces of paper in front of the child.

Informed consent

At least two or more weeks' notice was given to each family before their arrival for the stay in which the interview would take place, so that they had the opportunity ahead of time to ask any questions. During this time, the families were given online copies of the child and parent Information sheet and the Assent and Consent forms (APPENDIX B, C, D, E). If the parents desired a phone call, it was arranged to discuss any concerns or questions. A direct and ongoing dialogue between the researcher and each of the families involved took place before and during their induction into the study; this was to give them as much information as would be helpful and necessary and to answer any questions they had. At the induction itself, the child and parents were given physical copies of the Information sheets and the Consent and Assent forms and were walked through, each of them in a timely manner. They were given the time when the interview would take place and were invited to ask any questions they wanted. Before

the interview, the child was again asked if they had any questions and was read the Oral Briefing script. In the case of every participant in the study, the child and parents were well-informed and gave their consent, with the full understanding of what would take place in the interview.

Risk of harm or distress for participants

The researcher had five years' experience working at this facility and was, therefore, already familiar with the children, allowing the researcher to interpret and redirect the interview if there was a question that caused (or seemed to cause) distress or any other strong emotional responses. The researcher's experience enabled them to recognise topics that were sensitive, with the help of parents/caregivers/guardians before the interview. During the process of designing the interview, care was taken to ensure that the young children were able to share their experiences and perceptions in a respectful and safe environment. The researcher worked alongside both the Human Ethics Committee at the University of Canterbury and the research expert that was on the SIRCO's Board of Trustees to generate initial questions that were worded in such a way that were respectful and would not cause harm or distress to the child. The open-ended style instead allowed the child to control the level to which they shared and meant they could answer in whatever way seemed most fitting to them.

Cultural considerations

Considering the population that was being investigated included those of Māori heritage, it was vital to have a Kaiarahi consultation to communicate what the study would include and how it would align with culturally appropriate practices. A meeting was had at the University of Canterbury with a member of the Kaiārahi, College of Education, Health and Human Development team and a discussion followed about how to approach the study. Adopting Māori tikanga, such as the hui process, would allow for a culturally appropriate

framework to work within for the study. After this meeting, approval was given (APPENDIX I), and any questions or concerns were able to be directed back to this department if they arose during the study.

CHAPTER 4

Results

Participants

The study interviewed 8 children at the SIRCO with a purposeful sampling method. Due to time constraints only, a partial gendered split was obtained. Five boys and three girls were interviewed. Part of the purposeful sampling method was to have a mix of ethnicities that represented the SIRCO population but also the population of New Zealand. These children were identified by their parents/guardians/caregivers, and for their anonymity specific details will not be shared. These children were identified individually by their parents as New Zealand European, Māori and Pasifika. Their ages ranged from 8 to 12 years old.

The aim of this research was to explore and understand children's perceptions and experiences of short-term respite care. After the methodical analysis of the interviews (to identify themes that occurred in each of the individual interviews), the process of integration occurred and, from this, six superordinate themes were identified. These themes are further broken down into subthemes to better explain the breadth of the information gathered from the interviews. There is overlap between the themes but, overall, they provide separate ideas that can be understood and presented. Quotations from the children interviewed are included in their verbatim form to support each theme, however, quotes were edited for several reasons. Firstly, to ensure the confidentiality of the children's identities and those spoken about, including other children, staff, or parents/caregivers/guardians (all of whom were simply referred to — in or out of the quoted text — as the child's 'caregiver'). Specific non-essential details the children referenced were redacted to further limit any identification of the children. The text was also made more concise through the use of ellipsis in place of less relevant text

to show where an omission had been made. Omissions were also made to maintain the facility's anonymity. Some discussions in the interview themselves cannot be referenced directly at all, as specific situations spoken about could identify the child; these were still analysed and supported the formation of the superordinate themes. For these reasons, transcripts cannot be provided. Further analysis will take place in the Discussion Chapter.

Theme 1: Constructive experiences during the stay

Enjoyment of stay

The first theme that will be discussed is one that was talked about in depth in all the interviews. These are the constructive experiences that each child had while at the SIRCO. Throughout all the interviews, children shared multiple constructive and positive experiences of respite care. A portion of the interviews were devoted to the child sharing moments of their stay which they had enjoyed, and each child had moments that they found fun, calming, and exciting.

> ***Child:*** *"Well, first, it's, it's kind of, like, it's fun riding [a] bike … You get to play on bikes … Like sometimes biking is calming, especially biking on your own, sometimes. It's just calming."*

> ***Child:*** *"We got special paints to paint the penguin, and, ahh, I remember one of my friends called [redacted] made a camouflage one, and it was pretty cool."*

Some of the children expressed that the time they spent at the facility often contained these fond moments and that each of them contributed to the overall enjoyment of their stay at the SIRCO.

Constructive activities

Many of the children paired their enjoyment of their stay to the outings that they were able to participate in. The children expressed that there were many activities that occurred during their time that allowed them to enjoy themselves and have fun.

> ***Child:*** *"Sometimes we go on, like, we went on this hike, this really long hike and that was quite fun."*

> ***Child:*** *"Yeah, I like ice skating, and I, ahhh, we go for walks down to the beach. It's kind of fun. We, I learnt about how to tell, ahh, yeah, we found like dead crabs. And we, like, yeah, we walked on. Ahh, yeah, go for beach walks."*

> ***Child:*** *"So it's fun and, umm, it's, ahhh, I like it because we go on trips and like they take us mountain biking."*

> ***Child:*** *"I love coming, It's really fun because we go on lots of fun trips."*

> ***Child:*** *"It's fun ... yeah, fun and safe I think ... Because they let you go out to places and don't have to make you sit and do boring stuff the whole time."*

> ***Child:*** *"Going out places, doing outings and stuff."*

Children also described some of these activities as outings that they would not get the opportunity to do at home in their normal life.

> ***Child:*** *"Yeah, cause there is always something fun for them to do. Sometimes you do kayaking and sometimes you get to do anything, stuff you wouldn't normally do."*

> ***Child:*** *"Ummmm, sometimes we do things I wouldn't do at home, like activities and stuff."*

Positive peer relationships

When asked about how they felt about the SIRCO, children also expressed that their enjoyment of their stay was partly related to the friends they made during their stay.

> ***Child:*** *"It's fun and I'm always excited, especially when I know I'm gonna see a friend."*
>
> ***Child:*** *"Happy ... How do I feel? Happy ... Making new friends or seeing old friends."*
>
> ***Child:*** *"Well, yeah. But like, this is how to meet new people. And I'm actually kind of happy that I found some people that are into [Redacted] like me."*
>
> ***Child:*** *"Umm, sometimes playing with friends [is fun]."*

One child, when asked how they would describe the children who come to the SIRCO, spoke about the hard experiences that they themselves had gone through and noted that the other children who came had also been through hard things.

Child: *"[The children] Um, like, different ... stuff all, like, most of them have been, like, in the same position as, like, I have or something [Describes in detail another child's life as being difficult and sad]. It is quite similar ... [they are] a great kid, like, they're fun."*

This child identified that many of the children who came to the facility were those that had difficult and sad backgrounds, but it allowed them to bond and create friendships.

The children also reported that the staff themselves were a reason for their constructive experiences within respite care and that particular staff who worked at the SIRCO helped their enjoyment of their stay. Several quotes are not included as they refer to specific people and instances which could identify them, as children gave specific situations or specific staff names. Most of the children reported positive relationships with staff during their stays.

Child: *"Yeah. Like, I know all the staff ... And I like all of them ... Yeah, The staff make me feel safe."*

Child: *"[I feel] good and happy about the staff ... EEEEEKKKK (elated squeal) ... [I feel] Crazy happy ... They are really good."*

These statements from this child shows that they have developed strong connections with the staff at the SIRCO.

School

Children reported that they enjoyed staying at the SIRCO for multiple reasons, particularly because they enjoyed the school that was provided more than the regular school they attended.

Reinforcement of positive behaviours during stay

Forms of vicarious and direct reinforcement were reported during the interviews. These reports were of staff members' interactions or moments where they modelled positive behaviours to the child.

When one child was asked about how they felt when pushed outside their comfort zone at the SIRCO, they responded:

Child: *"Well, first I feel like scared and they, but like, if you, like, I remember once when I went to [redacted] we went on like a zipline, and I was standing on top — lucky I had that [the harness] on ... And I was scared, and they kept cheer[ing] me on ... And I said that, I said that I will do it because [another child] didn't want to do it. And I said I will do it, and they said to just lean back ... And then as they told me to lift my legs off, yes, my legs off. And then they told me just to be, like,*

it'll be fine. And I was like, because I was scared that [it] was going to break because I bet they're big … I was scared it was going to break, but it didn't break."

The researcher followed up by asking about whether it was a common occurrence for the staff at the SIRCO to get alongside them and support them when they felt nervous when being pushed outside their comfort zone.

Child: *"Yeah… [the staff help make it] feel comfortable most of the time. Yeah."*

When this child was asked further about how the staff at the SIRCO helped them to feel supported and calm when they felt scared, they added:

Child: *"So it's fun and, umm, it's, ahhh, I like it because we go on trips and like they take us mountain biking. And I remember the first time when I did mountain biking that, we, I was like a bit scared to go down. Big, like, go down the hill, going up and down. Like, if I lost control go that way. But I was perfectly fine. Went down, it was kind of scary because it was like a big rock that we couldn't go into. And I climbed the big rock and I couldn't get down … Yeah, they [the staff] helped me when I was feeling scared and like calmed me down."*

One child shared that they were made to feel safe during their stay due to staff dealing with high intensity situations and being able to recognise when they need to step in.

Child: *"[A child] lashed out, like, a lot [during a specific game] and [they] just keeps constantly swinging at me. I don't know why … [staff] handled it real well … Yeah, [staff] pulled them off me … Yeah, the staff make me feel safe."*

Multiple children acknowledged that when they were nervous or worried during their stay, staff got alongside them and supported them in a way that allowed them to become happier and begin to play games. There were also several children that specified particular situations

in which staff role-modelled constructive responses in dealing with children who were being — what the child being interviewed described as — annoying or irritating. These children acknowledged that these situations were helped by the staff members' responses to these situations.

Theme 2: Adverse experiences during the stay

Adverse peer relationships

The children also shared adverse experiences during their stay at the SIRCO. One of the most prominent of these adverse experiences were their exchanges with other children. Multiple children who reported that they enjoyed meeting new friends during their stay also reported that children during their stays were bullies, annoying, or mean. The reporting of this information was scattered throughout the interviews, often with specific instances of violence or bullying that were remembered by the child.

Child: *"I'm bullied here by people ... mean people."*

Child: *"Yes, people annoy me. I'm going to say the annoying kids here ... When kids are annoying me I just, I start being mean."*

Interviewer: *"And you described kids as annoying; is that all or just some of them?"*

Child: *"Some of them ... Depends on whoever's in."*

Child: *"Very irritating kids ... Annoying ... Just, it's just a personality trait."*

A few of the children specified that these instances of children being mean were worse than they had experienced at school. These instances were followed by specific examples which may identify them.

Facilities and school

Children shared that there would be things they would want to change about the SIRCO on a superficial level, including a bigger space to play and bunk beds to sleep in. Some children also shared about their experiences of the school provided at the SIRCO, saying the curriculum was too "easy" and geared towards younger children; they desired that it would provide more of a challenge. When one child was asked about how they felt about school they responded:

> ***Child:*** *"Umm, well I do lots of things. But we do things that are, umm, not really my year level ... I don't know, it's a piece of cake. I'm there. Like, I'd be like, well, this is too easy ... It's just easy so it's fast and that ... I am sometimes like, can I just go to normal school so I can do my normal school work?"*

Theme 3: Self-beliefs about why they stay at the SIRCO

Positive self-beliefs

During the interviews one child expressed that they think part of the reason they go to the SIRCO is because they enjoy being there.

> ***Child:*** *"I think one of the reasons is partly sometimes I like it. Then I say I'll come back the next time. [My caregiver] says okay, well, then go again."*

This child later discussed the other part of why they believed they came to the SIRCO, which was a negative belief about themselves.

Negative self-beliefs

Multiple children who were interviewed shared their beliefs about themselves which were negative, especially when reflecting on the reasons why they believe they attended the SIRCO. One child, when asked about why they came to the SIRCO, replied:

> ***Child:*** *"I think it's so I give [my caregiver] a break ... Just a break from us kids ... Because I get out of hand sometimes and I am a bit coocoo and that ... Lots of the time, I'm crazy."*
>
> ***Interviewer:*** *"Have people told you that you are crazy?"*
>
> ***Child:*** *"Well, yeah."*

This exchange shows the belief that they are the reason why they have been sent into respite care. One child, when asked about what happens if they were sent home early, their response was:

> ***Child:*** *"[My caregiver was] angry that I didn't stay the whole time ... cause [my caregiver] doesn't want me in the house ... Because I think [my caregiver] hates me."*
>
> ***Interviewer:*** *"Do you think that is true?"*
>
> ***Child:*** *"Yes ... I find it hard"*

This child believed that their caregiver did not want them in the house and that they hated them, which is why they were at the SIRCO. One child shared that the reason why they believed they came to the SIRCO was because they had anger issues.

> ***Interviewer:*** *"And did you say that [sibling] has anger issues, did you say?"*
>
> ***Child:*** *"Yes. And so do I."*
>
> ***Interviewer:*** *"Do you?"*

Child: "*Yes."*

Interviewer: *"Well, umm, is that why, umm…"*

Child: *"I think so."*

Interviewer: *"Think what?"*

Child: *"I think that is why I'm here."*

Interviewer: *"Oh you think that is why you are here — because you have anger issues?"*

Child: *"I think."*

Later, this child also expressed that they believed themselves to be a psychopath, when asked how they felt about their anger issues possibly being the reason why they had to came to the SIRCO.

Child: *"[I feel] weird."*

Interviewer: *"Weird. How would you describe weird?"*

Child: *"Psychopath ... Yeah, [it is] a bad thing ... Cause I don't want to be a psychopath.*

Interviewer: *"Why do you think that you are one?"*

Child: *"Ahh, cause I get called it."*

Interviewer: *"So, because you get called it, means you are one?"*

Child: *"Yes."*

When asked about why people started calling them that, they did not know. They reported that in other areas of their life they are referred to as a 'psychopath'. This child shared that the staff and children at the SIRCO do not call them 'psychopath' but went on to say that they believe people at the SIRCO will begin calling them that.

One child shared that they believed that they cannot be handled because of their behaviours.

Child: "*Because [my caregiver] can't handle me with my [behaviours]. When I get mad, I threaten people and that. It's alright, it's the way I've ever been."*

This child held the belief that their behaviours were strictly a result of their own bad choices, and they also maintained that this was the way that they had always been, accepting that they are this way with some finality.

Child: *"Yeah, I think [my caregiver] just needs a break ... [from] me ... Grown-ups needs breaks from their [child]. Is that not true?*

This child expressed that they believed that most parents need a break from their children and that this was a normal experience for every child. One child also expressed that it is not only their caregiver that they are here to take a break from but other family members as well.

Child: *"Especially right now cause I'm living [with a family member] ... we don't get along ... [the family member] doesn't get along with me."*

This child's beliefs about why they are attending this facility is due, in part, to the belief that they do not get along with a particular family member.

Theme 4: Attendance autonomy

A few children expressed that they are always aware of when they are staying in advance and that it helps them to feel excited about coming.

Child: *"[My caregiver] doesn't send me, like, just send me. [They] always has it like planned out. Yeah. Like I know like [several] weeks before ... Usually I am the one who asks."*

This response indicates the child looked forward to their stays and is often eager to return to the SIRCO. This could also help the child feel more in control of their stays by knowing so far in advance.

Children expressed during their interviews that there are situations where they feel as if they are forced to go to the SIRCO even though they do not want to, and in the cases below participants even recall being lied to by their caregiver to influence them to go more willingly.

Child: *"Yeah, I don't want to come. Because I don't want to come to stay. I wanted to like go home and [my caregiver] said just stay there. Just enjoy it … [My caregiver] will force me to go … [they] just say, "You're going." And every time I want to go home, [they] just says, "No, you'll enjoy yourself," and yeah … I get angry and we have fights often. I yell — I kinda just keep yelling and angry and saying, "Yeah, why you force me to do this? I don't want to come! Why?" and then blah blah blah … [they] says, "Just because." Yeah, nah, yeah. [They] lie that [a friend of mine] is coming [to the SIRCO] to get me to go."*

Children also expressed that, on occasions, caregivers would attempt to bribe or encourage them to go by giving them food or buying gifts for the child if they just stayed there.

> ***Child:*** *"Yeah. When I called [home], I said I wanted to go home. They said, "Oh, [no you can't]." … [They are] annoyed but also [they are] a bit cheeky and [they] end up … telling me, "Just stay there," and then [my caregiver] will be like, "Just stay there. You'll be fine. You'll be okay." And then I was like, "No, I will feel homesick." And [they] was like, "Oh, you're going to be fine." "Fine, I'll stay for a whole week." Then they said [that they] owes me $30 … [they] said they would buy me [items] and, ahhh, I forgot what the other one was … like [they] said, "I'll pay you, I'll give you money," and I said, "No, I don't, I'm not doing it for money*

or [items] and that." And [they] said, "I'll give you it, I'll give you money, [items] and all that if you stay." I'll be like, "No," and [they] said, "Just stay." Then I'll be like, "Fiiiinne." Yeah, cuz I usually, like, usually I don't want to come … [they] says [they will] put money in for my [expensive item]. Because [they] says [they will] give me a [expensive item] I do not believe [them] haha."

This child explained that the expensive items or money that they had been promised were never followed through on and that they knew that their caregiver was lying just to get them to stay there. A few children shared how they had consequences if they were sent home early from the SIRCO. In one instance a child seemed saddened that they would get in trouble for being sent home.

Child: *"Yeah. If I come home early, I lose my strikes … Umm, if I'm naughty I lose one."*

Interviewer: *"And coming home early from [the SIRCO] is being naughty?"*

Child: *"I lose all my strikes then. It's not fair … I want it cancelled"*

This child was adamant that they thought they shouldn't be punished for not wanting to stay at the SIRCO. One child reported that when they were told they were coming to the SIRCO that they felt heavy, which was due in part to leaving their caregiver. One child expressed that, in the past, their sibling was allowed to go home but they were not.

Child: *"Yeah, [sibling is allowed to] go home … Oh [they] cause, umm, [they] complained [more than once]. And, ahhh, I don't know. I think just because [they are] younger and I'm older. [They are similar in age to] me though."*

They went on to discuss their frustrations with attending the facility and about how they cannot go home, which annoys them. Another child spoke of a time when they wanted to go

home, and they recognized that they had be behaving poorly but also knew that their caregiver would be angry at them for going home early.

> ***Child:*** *"I want to go home … [describes specific situation in which they got angry at staff] … I got angry."*
>
> ***Interviewer:*** *"…Why did you not go home then?"*
>
> ***Child:*** *"[My caregiver] will be angry if I go home."*

The child knows that they may get into trouble if they go home, which shows their parents/caregivers/guardians do not allow them the autonomy to choose if they wish to be there. During that same interview, the child identified that staff had asked them if they wanted to go home because of their behaviour and the child had told the staff member that they would stay and work on controlling their behaviour.

Theme 5: Wanting to help their parents, feeling responsible for their parents' wellbeing

One child expressed that they were understanding as to why their parent needed a break from them. They believed that it was partly their responsibility to care for their parent by going to the SIRCO.

> ***Child:*** *"Oh so [my caregiver] can have a break and so I can have fun … Like at home, sometimes [my caregiver] gets annoyed at us, but that's not the worst thing. [My caregiver] likes [when we go to the SIRCO] and [they] can do stuff with [their significant other], like go out every night and not worry about us. Like they can go to [places] and they wouldn't have to worry about us … I don't really mind … It means [they] has fun at home … Like, I understand being a [caregiver] is hard. And [my caregiver] — it's much worse for [them] because [they have personal reasons]. That's not [their] fault that's just [their] brain. But I understand*

if [they] wants to have a time, some time away from us and it's okay because every [SIRCO] trip has been timed perfectly."

This child expressed their contentment about coming to the SIRCO, but they held the belief that, without them being at the SIRCO and thus completely removed from the home, their caregiver would not be able to have a break. This child continued discussing this, saying that they also felt like they have to care for their caregiver and look after them because they need help.

Child: *"I have to [care for my caregiver] like [my caregiver], you know, isn't like disabled-disabled, but sometimes [they] needs help around the house, which I do most of the jobs, me and my [sibling] do some jobs. [My caregiver's significant other] helps with a jobs sometimes."*

This child expressed that they feel the need to care for their caregiver and coming to this facility was a way that they could care for their caregiver. The child continued discussing that they feel worried about one day being too old to come to the facility so they would not be able to help their caregiver by giving them a break. When asked about what they will do when they age out of the program at the SIRCO, they responded with:

Child: *"I don't know. That's exactly the problem I don't know… [I feel] worried … Sometimes [my caregiver] needs time to [themselves] … Makes me feel like [my caregiver] is not getting enough time to [themselves]. [They] never get time to [themselves] now that [my former secondary caregiver] is gone. Cause [they] can't go out because, like, there's nobody to look after us … [When I am fourteen my caregiver] said I can look after myself and my [sibling]."*

This shows that the child is taking on developmentally inappropriate responsibilities to care for and look after their caregiver and try to provide them with what they need.

Theme 6: Emotional adjustment to stay

When asked about how they adjusted to their stay at the SIRCO or how they felt about attending, the children provided a varied mix of responses — some positive emotions and some negative emotions. A few of the children spoke about how they felt happy and excited during their stay at the SIRCO. One child, when asked about how they felt during their stays at the SIRCO responded:

> ***Child:*** *"Good, cause we get to do lots of fun things … I'm happy — happy and excited."*

This is one of several participants that expressed that they adjusted to their stay at the facility well. Children expressed that they often had moments in which they really enjoyed being at the SIRCO, but during the interviews children also identified other feelings.

> ***Interviewer:*** *"When you go home after [being at the SIRCO], how do you feel about that?"*
>
> ***Child:*** *"Sometimes relieved and sometimes happy … Cause maybe sometimes there are mean kids and I don't want to come back … If I came here, [I feel relieved] a lot I guess … Sometimes it's annoying, and I'm happy I have to come home."*

When a child was asked about how they feel when they are at the SIRCO, they replied with happiness. Later in the interview when the child was asked if there were any other emotions on top of happiness that they felt, they added that they felt worried.

> ***Child:*** *"Worried"*
>
> ***Interviewer:*** *"Worried? What do you feel worried about?"*
>
> ***Child:*** *"I do not know what makes me feel worried for some reason… If I had to guess, I don't know."*

This conversation continued, and the child said that when they felt worried, they would cope by either going to have a play or by using one of the rooms at the facility that was designed to be able to calm them if they felt worried. They went on to share that they feel worried at home most of the time, which is the same worried they feel during their stay at the facility.

The results found in the interviews show a diverse range of experiences that each child had. The six themes highlight the findings which will be analysed in the following chapter.

CHAPTER 5

Discussion

The present study's aim was to explore how New Zealand children perceive and experience short-term respite care provided as a support intervention for families with parenting difficulties. This was undertaken using semi-structured interviews with children who had experience staying at a South Island–based respite care organization (SIRCO). An Interpretative Phenomenological Analysis (IPA) uncovered six themes that are specified in the results section and will be discussed and interpreted below. The interviews revealed many things about children's experiences and perceptions of short-term respite care, and though it was more specific than past literature, the current study's findings were consistent with other works (Minkes et al., 1994; Read, 2008; Schroder et al., 2014; Stewart, 2017; Uhrman et al., 2019). The current study will be compared to the past literature to further highlight the consistencies in this field, and new findings and deviations will be introduced and explored.

Within the data — where specific situations or themes are present across multiple participants — the number of children who these pertain to will not be reported; this is to protect their identity and to avoid a quasi-quantitative interpretation of the qualitative findings. Although the present study's methodology means that the findings cannot be generalised to the entire population, the participants represent the population that they were drawn from. These findings give credence to the current exploratory study, indicating areas of discussion and warranting further investigation.

As was reviewed earlier, children stay at respite care facilities or camps due to the caregiver's lack of capacity or lack of parenting skills, and there is evidence that suggests that the benefits of respite care for parents will positively impact the children they care for (Caples & Sweeney, 2011; Day et al., 2018; Harper et al., 2013; Jeon et al., 2005; Madden et al., 2016;

O'Brien, 2001; Piescher et al., 2008; Pollock et al., 2001; Strunk, 2010). The SIRCO under investigation in this study provides a service that caregivers and parents alike use, giving them a better chance to parent well. Whilst the benefits of respite care for supporting caregivers — who either have children with a high burden of care or who struggle with regular caregiving responsibilities — have been well documented, researchers have often overlooked or ignored the child's experience of respite and how they perceive it. The SIRCO in question has recently begun to use surveys for the children at the end of their stays, which is a good step toward listening to the child's voice in relation to their stay at the facility. The summary of findings following will discuss the six subordinate themes highlighted during the interviews.

Summary of findings

Theme 1: Constructive experiences

A key finding of this study was that children perceived many different 'constructive experiences' within their time at the SIRCO. The term 'constructive experiences' is used to describe the areas discussed by the children which were considered beneficial to their development. These can be separated further into four categories: enjoyment of stay/activities; developing friendships; school; reinforcement of positive behaviours. These classifications allow for further discussion about how and why they are constructive to the child's experience at the SIRCO.

Enjoyment of stay/activities:

Children identified that one of the constructive experiences during their stay was related to the activities they got to do on outings and activities which were provided at the facility. The reports were that the children derived great enjoyment from being able to participate in fun activities during their stay, and these memories held a firm place in the children's minds when they articulated their perceptions about their stay. Many specific examples were shared

during the interviews about the activities the children were able to participate in: biking, kayaking, beach walks, hikes, and more were at the forefront of their minds. The children's enjoyment of their stay was conveyed through their mentioning of these experiences, and the importance that the children placed upon them was clear.

This theme was further manifested through children expressing how they felt that their visits to the SIRCO allowed them to participate in the activities that they would not be able to have access to in normal everyday life. This is an important finding and highlights the beneficial impact that these facilities can have, in giving the children an enriched and diverse experience. Much like the therapeutic respite care summer camps Stewart (2017) discusses, respite care stays allow children to enjoy games and activities that would be inaccessible otherwise, for various reasons. With the understanding that the SIRCO used for this study supports disadvantaged families, a correlation could be made that the families of the participants cannot afford to take their children on such outings or activities normally. Poor financial priorities, ill-health, or underdeveloped parenting ability may also be factors that contribute towards why these parents/caregivers/guardians seldom provide these kinds of experiences for their children/the children in their care. Being given the opportunity to participate in diverse outings and activities is beneficial for all children and their development. These repetitive learning experiences in respite care settings may therefore provide opportunities, according to the Neurosequential Model, for children to gain skills and grow in developmental areas not mastered in their current home environment (Perry & Hambrick, 2008). Literature in this area advises that children participating in outdoor activities can have multiple advantageous outcomes; commonly, the child enjoys the excursion but also benefits in their health and wellbeing (McCurdy, Winterbottom, Mehta, & Roberts, 2010; Rivkin, 2000). This would suggest that the outings and activities that children able to do at the SIRCO

are providing opportunities and experiences that benefit the children's physical and emotional health.

Developing friendships:

Another constructive experience was the friendships that the children were able to establish during their stays at the facility. The relationships they developed with not only children, but staff too were clearly stated in the interviews and were important aspects relating to how the participants experienced their stay at the SIRCO. These findings echo that of the studies reviewed in Chapter 2, which showed that children's stays at respite care facilities/camps were positively influenced by making friends with children and staff alike (Minkes et al., 1994; Stewart, 2017; Uhrman et al., 2019). The importance of this cannot be stressed enough, as these relationships were able to be cultivated and maintained during their stay and beyond. In the current study, children reported being able to reconnect with friends made over the course of multiple stays and looking forward to coming to the SIRCO so they could be with those friends again. The reports from the participants, that their friendships with children and staff were of such quality that they were positive influences on their perception and experience of their stay, is significant. This is for two reasons: firstly because, as is well established, friendships form a substantial component of psychosocial development for children (Vitaro et al., 2009). Secondly, these positive relationships reinforce the children's own perceptions that their stays at the SIRCO are enjoyable and can influence them to want to return.

One child in their interview identified that many of the children who came to the facility were from difficult backgrounds, which implied they would not have an opportunity to meet one another in their everyday environment or activities. However, the child used this to form and connect with specifically one other child who had gone through similar things. This

connection point allowed for a friendship to blossom, which they would not have been able to begin if they were not at the SIRCO together.

School

Some of the children described enjoying the school provided at the facility more than their regular school. This may mean that these children engaged with the learning more or at least were not as opposed to being there. The enjoyment of school at the SIRCO could have also been due to what some other children observed, which was that it was much easier than regular school, although that factor was raised by one child as being unfavourable.

Reinforcement of positive behaviours:

The children discussed staff who were most significant to them and described their positive relationships with them. A few of the children discussed instances in which staff stepped into situations and helped them to resolve conflict between themselves and other children. In applying an understanding of social learning theory, these relationships between both children and staff could provide instances of direct and vicarious reinforcement for the children (Bandura & McClelland, 1977). The staff, by intervening in these situations, allow for conflict resolution to be learned or observed, giving examples of direct or vicarious reinforcement. In other situations, children highlighted that they felt safe at the SIRCO. This is a constructive experience for the children because it helps them to have a secure environment that facilitates exploration and learning.

From a social learning theory perspective, it is clear that the staff provide the children with positive reinforcement during their stays, often as they participate in activities. This is evident by the discussions had in the interviews. One child described an instance of ziplining and how they were scared but the staff provided support to them. The staff did so by communicating confidence in the equipment that the child was using. The staff member was

not fearful and did not express worry, which allowed the child to learn through direct reinforcement that the zipline was fun and safe; this would also benefit the others watching who would learn through vicarious reinforcement. In summary, the positive reinforcement demonstrated by the staff at the facility allowed the children to safely express their emotions and work through them so that they could try new things and build their confidence.

A further point of discussion — although not highlighted in the results section — is the subject of secure attachment figures. The SIRCO provides secure attachments figures through the attuned staff members, who were described by the children in their interviews as being reliable, safe, and trustworthy. One example in the interviews was a child talking about an experience on a mountain bike trip that they had where they were supported and comforted by the staff when they felt scared. The secure attachment figure that staff could provide for the children who attend the facility is an important aspect to consider when understanding the possible correlation between insecure attachments and placements in respite care. There is evidence to suggest that teachers can develop a secure base for the children while at school through an attachment oriented intervention (Ubha & Cahill, 2014). There could be some quality to the argument that a respite care organisation, through the attuned and responsive staff members, could provide children with a secure base during their stay.

Theme 2: Adverse experiences

Children did not express solely positive experiences or perceptions of the SIRCO; they also shared their difficulties. Of the adverse experiences they recounted, instances of other children being annoying, irritating, or exhibiting bullying behaviour were, by in large, the most repeated. Children of this age do experience these behaviours from other children at school, but in this circumstance a few children did express instances that were memorable or what they considered worse than normal school behaviours. Participants did not only complain about children being angry and mean verbally but also physically. One child spoke of an example

when another child was trying to attack them, and a staff member had to intervene. With what is known about children who are most likely to attend respite care, this does align with contemporary theory, as children who exhibit increased externalising behaviours are recommended to these support services (O'Connor & Zeanah, 2003).

The theory of latent vulnerability suggests that children who come from homes where maltreatment is present have an increased risk of later oppositional behaviours or dysregulated emotions (McCrory & Viding, 2015). Within the current study, participants made comments that inferred they felt the children at the facility were louder and more disruptive when compared to children at their schools. There were also children who identified themselves as angry and/or as bullies when they did not get their own way, needing staff intervention to stop them acting inappropriately. For these reasons, further studies are recommended to investigate whether children who attend respite care facilities do feel like the behaviour is worse than at school and also whether children feel unsafe in these environments because of other children. This is advisable because there are indications in the literature that developing friendships which are highly conflictual or of low quality with persons who have adjustment problems or deviant behaviours can be detrimental to psychosocial development (Vitaro et al., 2009). As the children who attend respite care in these instances are from disadvantaged families with increased likelihood of behavioural difficulties, it could possibly indicate that these friendships could provide negative psychosocial development.

Another note to make is the children who reported finding the school provided at the SIRCO to be too easy, stating that they wished to be at their own school. It must be said that the school provided is catering to a wide range of ages (three to twelve years old) and developmental ability. The SIRCO has school curriculum specifically aimed at the older children and the younger children however, with children finding it two easy there could be

less buy-in for those children and it may make those children feel behind in their normal schools.

Theme 3: Self-beliefs about why they stay

The beliefs that children had about themselves about why they stayed at the SIRCO were not a true reflection of why respite care is provided for them. The participants discussed the break that their caregivers were having from them, often indicating that they believed they were the prime reason for why they had to attend the respite care facility. If this were for a child with a high burden of care due to physical or intellectual disability, then this belief would be correct; however, as discussed earlier, modern respite care has evolved to provide for a wider variety of circumstances. Broadly speaking, it is offered as a protective factor for disadvantaged families with limited capacity or skill to parent, meaning that, generally, respite care is more about the parents' deficiencies — as opposed to the child's (B. Drake & Jonson-Reid, 2014; Kissman, 1999; Read, 2008). Therefore, it is not due to the shortcomings of the child but the caregivers.

As reported in the results section, there was one child who said that they were often eager to attend the SIRCO, and their parents knew they enjoyed it. This child, however, later disclosed the belief that they came because they were a burden to their parent. This was a common finding of the current study, with many of the children indicating that they believed that they and their behaviours were the reason for their stay. The participants perceived that their caregiver needed a break from them and their annoying or irritating behaviours. In a few instances, the discussions with the child showed that they believed that their caregiver hated them or could not have a break without the child leaving. Not only are these negative beliefs not based in the reality of why respite care is provided, but they could be harmful to the child's development and sense of self (George et al., 2006; Webster-Stratton & Herman, 2008).

It is important to note how the direct reinforcement of ‘going to respite care’ sits in strong contrast to the framing of the opportunities that occur when a child is given the chance to go on a school trip or a vacation or holiday camp. In these instances, children are reminded that it is a privilege, and the most well-behaved children get to attend. However, with respite care, a child will be sent there no matter what their behaviour. Even at the SIRCO, an anecdotal observation of the researcher’s would be that this contrast is further highlighted when there are special outings, as these are always framed in an explicitly positive way; the children are encouraged that those who are well behaved will be allowed to go. Similarly, school excursions, while predominantly serving educational purposes, inherently reinforce perceptions about the kinds of experiences or places which are favourable and a privilege, and what type of children get to attend them — i.e. those who are lucky and/or good (Millan, 1995). This is not the case for the sample population regarding their perception about attending the SIRCO. To summarize, some of the children perceived being sent there as a means to give their parents a break, while in other cases, the children saw their attendance as being the result of their poor behaviour. In zero of the interviews did the child describe coming to the SIRCO with the belief that it was a reward.

As discussed previously, children who attend respite care facilities can be those who have parents with limited parenting skills and/or low capacity to parent (Aldridge, 2006; Donald & Jureidini, 2004). Children in these positions also have an increased risk of forming insecure attachments with their parents, due to these limitations (Baer & Martinez, 2006; Gordon, 2003). These attachment styles persist into childhood and can exhibit themselves as externalising behaviours, which generate negative responses from caregivers (Rees, 2007). Children who display externalising behaviours can also have an increased likelihood to be sent into respite care and be least likely to be able to cope with repeated separations (O'Connor &

Zeanah, 2003). These factors indicate that the children interviewed may have had insecure attachments with their parents.

Attachment theory gives the understanding that insecurely attached children develop maladaptive internal representations of being parented and are 'primed for insecurity', thus interpreting extended separations from their parents/caregivers as a catastrophic loss (Tarren-Sweeney, 2016; Tarren-Sweeney & Goemans, 2019). Furthermore, these children — because of their internal representations — can interpret these stays at respite care centres as abandonment and evidence that they are inherently bad or unlovable. The results found in this study of children describing themselves as hated by their parents, being a 'psychopath', or being 'coocoo' could be a result of insecure attachments which are being perpetuated by their stays. The findings of the current study display that the children's self-beliefs were that they were the precipitating factor of their stay; this was evident as they discussed their poor behaviour and anger issues as being the cause. This self-belief went to the extent that there was the suggestion by some children that they were annoying and that their caregivers hated them.

Having negative self-beliefs is a high-risk factor for a child's later mental health disorders (George et al., 2006; Webster-Stratton & Herman, 2008). The belief that oneself is the cause of distress/frustration to their parent could be a significant weight for a child. Children who report lower self-worth and self-esteem are those who do not perceive parental support and who perform poorly in areas of importance to their parents (Killeen, 1993). If the children perceive that their attendance to respite care centres is due to their poor behaviour or actions, then this could possibly decrease their self-worth or self-esteem. With the understanding that self-esteem has been linked with increased vulnerability to depression and anxiety later in life, this issue is significant (Sowislo & Orth, 2013). These findings may suggest that respite care could have the paradoxical effect of benefitting the child in the short term — with the numerous

aforementioned benefits — but at the same time, causing the child to develop negative self-beliefs that could have harmful effects on their self-worth and future mental health well-being.

The results can also be examined using the social learning approach and social cognition regarding how the children interpreted why they were attending the SIRCO. Social learning theory suggests through direct and vicarious reinforcement children learn about the environment around them (Bandura & McClelland, 1977). In the findings, these forms of reinforcement were highlighted through the children reporting that they needed to stay at the SIRCO to give their caregivers a break. Some of the participants reported that their parents told them directly that they were staying due to their behaviour or because their caregiver needed a break from them. Other children learnt this negative perception of respite care vicariously, because the parent spoke to a sibling in that manner. Social cognition suggests a similar process where the child learns by observing and listening to their parent and adopting their explanation as to why they attend (Fiske, 1993; Fiske & Taylor, 1991; Tory Higgins, 2000). Each of the children interviewed developed their own beliefs due to these observations, and all had deduced that they or their sibling were at the SIRCO to give their caregivers a break. This idea is further explained by causal attribution, whereby, when the child is sent to the SIRCO, they attempt to make sense of their stay by making a causal inference from their parents. Without situational context to which the child could attribute their stay (e.g. the caregiver is not dealing with their poor mental health well) the child makes a causal inference that their behaviour is the cause of their stay.

Theme 4: Attendance autonomy

When considering the current SIRCO and the autonomy the child has on whether they attend, there is some choice, but it is minimal. The child's consent to their stay is not required for the child to stay at the facility. It is possible during their stay for the child to go home if they wish, but it is dependent on the reason for their stay. Consent forms are used by the facility

to ascertain the permission of a parent/caregiver/guardian for their child to stay, but no policy requires that consent is given by the child themselves. Ultimately, at this facility if the child's behaviours are unmanageable or if they continue to request to be sent home, they will be, but their permission is not sought out in the initial induction. To the contrary, the findings of the current study suggest that multiple participants who attend the facility perceive being forced to go and having minimal control over their stays. Giving a child the ability to consent to their stay is a consideration this study puts forward, but there are also factors to consider. If children choose not to attend, this could increase the likelihood of repercussions for them as a punishment, which may be a reinforcer of negative self-beliefs. If they have an anxious insecure attachment, they may be choosing non-attendance to minimise their own anxiety and that may not, therefore, be a reflection of their possible enjoyment during their stay. In the current study, children reported that their poor behaviour could have them sent home early and then punished for doing so. This was spoken about either by the child explicitly stating their punishment or saying that their caregiver would be angry at them. One example of this was the child who referred to losing all their strikes if they were sent home. If children do not want to attend the facility, then they should not be punished by their family members, as punishment could overshadow one of the main objectives of respite care, which is to give the child a safe and fun environment. There are anecdotal observations from the researcher's five years of experience working at the SIRCO that during most stays, at least one child from the group would be sent home early. From the researcher's experience, this is usually due to a child behaving in a manner which made other children unsafe. An official study would be needed to corroborate this, however, it was outside the current study's realm of investigation.

For one child who expressed early in the interview that they had fun at the SIRCO but were worried about being there and wanted to go home, the reasoning the child gave as to why they did not go home was that they knew their parent would be angry at them. The child then

described a situation where they had become angry at the staff and had been unmanageable. Their behaviour at the facility indicated to the researcher that the participant was conflicted — wanting to go home but also, at the same time, not wanting to make their caregiver angry. This situation (of feeling unable to return home earlier) would perpetuate the insecure attachment between the parent and child and could be one reason why a child spoke about their belief that their parent hated them.

If children believe that they have no autonomy on whether they attend respite care, then their attachment relationship with their parent/caregiver/guardian may be affected. As discussed earlier, children who are from disadvantaged families have an increased risk of being maltreated, and they also are at risk of having insecure attachments (Baer & Martinez, 2006; B. Drake & Jonson-Reid, 2014; Gordon, 2003; Read, 2008). Children who have insecure attachments are, in some cases, threatened by their caregivers with abandonment, which can make the child intensely anxious and distressed (Bowlby, 2005). These threats can be used as a means of control over the child to influence them into more compliant behaviour. The consequence of treating a child in this manner, could be that the child might believe that if they stay at the facility that they are being abandoned and hence may associate staying at the facility with abandonment. The separation anxiety that the child experiences by staying at the facility could also be exacerbated by feeling that they have no choice in the matter. The lack of choice of whether the child stays or not could be causing them to behave poorly at the SIRCO, with the unconscious hope that by doing so, they may be sent home, alleviating their anxiety. The child might be willing to face the consequences of being sent home because they perceive it as more favourable than experiencing the continued separation. This could possibly be a contributing factor as to why at respite care facilities there are regular exhibits of externalizing behaviours.

Some children expressed knowing about their stays in advance, which they identified as being significantly beneficial for them as they enjoyed their stays and it allowed them to expect and look forward to them. This would allow a child to anticipate the separation in advance and, thus, diminish the separation anxiety by being able to prepare themselves. Therefore, a recommended method to families for how to best prepare their child for a respite care stay could be to give them the dates they are going well in advance. The children whose parents/caregivers/guardians did use this method expressed that, while they did not have a choice about whether they went, just knowing in advance when they had a stay coming up allowed them to anticipate it and not be surprised or feel like it was used as a punishment.

Theme 5: Wanting to help their parents, feeling responsible for their parents' wellbeing

During the interviews, there was an instance of a child discussing how they believed that they had to care for their parent, and it was their responsibility to do so. The child discussed that they felt that they needed to come to the SIRCO so that their parent would be able to have a break from parenting, and this same child also mentioned having to take on a number of responsibilities around the house. There could be some extent to which this child was experiencing parentification because they felt responsible for the parent's needs. Parentification is when a child takes on the roles and responsibilities usually reserved for adults (Hooper, 2007). There is evidence to suggest that role reversal or the parentification of a child can increase the risk of negative outcomes during development as discussed in Chapter 2 (Earley & Cushway, 2002; Hooper, 2007). There is also often an association between parentification and neglect (Hooper, 2007). This occurs through the parent delegating their roles as a parent to the child, which manifests through the child having to respond to the emotional or physical needs of the parent or siblings (Hooper, 2007). These findings also display that the use of the SIRCO might contribute to the ongoing reinforcement of this parentification behaviour. If the child believes that they have to care for their parent, then they

may feel like they need to repeatedly ask to come or express their enjoyment of their stays so that the parent can have time for themselves. The implications of these findings indicate the need for policy changes at respite care centres to identify if a child has parentification behaviours and if it warrants other services to be contacted. It must be considered that some children have solo parents and, where this is the case, there is evidence to suggest that taking on a somewhat parental role is not as harmful (Valleau, Bergner, & Horton, 1995).

Theme 6: Emotional adjustment to stay

The findings of the current study highlighted that children who stayed at the SIRCO experienced varying emotions during their stay, in both positive and negative ways. The interviews identified the children's perceptions of enjoyable elements of their stays, one being that they had positive experiences which led to a positive emotional adjustment to their stays. This is an important finding, as many of the children expressed how the activities they experienced at the facility and on outings were key in helping them feel comfortable at the SIRCO. Multiple children inferred that, during the majority of their visit, they felt a positive emotional adjustment to their stay. This demonstrates that the staff at the facility are working well on the whole, to help children feel safe, secure, and comfortable to be emotionally 'themselves' there.

The interview results also showed that not all the children adjusted to their stays in positive ways. There were reports in the interviews of the children finding it difficult to adjust to their stays at the SIRCO. These conversations emphasized how some children were looking forward to going home and that their interactions with the children at the facility meant that they could not feel safe during their stay. There were children who felt worried and one that expressed that they sometimes feel relieved or happy when they could return home. These examples display how the children did not feel entirely emotional adjusted to their stays; however, this in nonconclusive as there are different possible reasons why this may be the case.

The results show that some children had a dislike for stays due to their anxiety about being away from their parents/caregivers/guardians. This could be indicative of poor attachment experiences that highlight the child's inability to cope with repeated separations (O'Connor & Zeanah, 2003). If the child identifies these instances as abandonment, then it could perpetuate the already poor attachment relationship. With other studies suggesting that insecure attachment predicted later symptoms of both depression and anxiety, a clearer understanding is needed about respite care and its effects (Lee & Hankin, 2009). With considerations to the range of ages of the children who attend the facility, the youngest being 3 to the oldest being 12, there is an understandable reason for younger children to feel separation anxiety about their stay. Younger children are more likely to feel anxious about being separated from their caregivers for prolonged periods (Eisen & Schaefer, 2007). Of the children interviewed who expressed worry or concern for missing their parents and staying, they were predominately the younger participants. The SIRCO aims to reduce these feelings by allowing children to have shorter stays on their first few stays and often sends them with siblings to help them have a familiar face. The children being interviewed were those that had been at the facility multiple times, most having many stays over several years, yet some still reported these feelings of anxiety. As discussed previously, children who are insecurely attached to their parents may feel heightened anxiety due to fears of abandonment and, thus, may feel worried during their stay and relief upon return (Bowlby, 2005). This could be due to parents threatening their children with stays at the facility, which could have profound implications as it is suggested that the threat of abandonment is the cause of the most intensive forms of separation anxiety (Bowlby, 2005). If this was the case, then it could explain why feelings of anxiety persist for some children over years of attendance.

With many of the participants of the study reporting adverse experiences with other children at the SIRCO, it must be considered as to how this may make a child's emotional

adjustment to the facility difficult. Social conflicts, as one contributing factor, may also be exacerbated by the relatively unfamiliar environment, the exposure to strangers, and the significant age gap between the children — with older children more prone to displaying externalising behaviours. For younger children, this may appear intimidating and be a source of anxiety during their stay or relief when they return home. One child likened the worry that they feel at the SIRCO to the worry they feel at home; they then described how, at home, their sibling physically hits them. This child's descriptions of their experiences of worry, both at home and at the SIRCO, could mean that they feel like their physical safety is at risk from other children at the SIRCO. If this is the case, then this could explain why some children adjust poorly to their stay.

The world-wide COVID-19 pandemic may also have been a factor with the children being required to stay at the SIRCO and away from their families. The pandemic has decreased the mental health of both parents and children during this time (Whittle et al., 2020). Children with insecure attachments may have found that staying away during this period has decreased their adjustment to their stays. Two final location-specific considerations also need to be made regarding the children's emotional adjustment to their stay, and these are concerning the earthquakes and mass shooting that took place in the South Island region. There were several significant earthquakes in the South Island region where the current study was conducted (Christchurch September 2010, Christchurch February 2011, and Kaikōura November 2016) and thousands of aftershocks. Natural disasters such as earthquakes and the aftermath of this severity can leave lasting impressions on children's development and result in post-traumatic stress symptoms in the children who are affected (Liberty et al., 2016). These earthquakes could have had a lasting influence on the children that were interviewed and could possibly be a factor as to why children adjusted poorly to their stays. Due to the developmentally sensitive age of the children at the time of the earthquakes, it is also possible that this is a reason why

children's externalising behaviours became exacerbated (Liberty et al., 2016). These behaviours, as discussed previously, can be precursors to requested stays at respite care facilities. This could also could be due to the households that these children were living in, as many children who had increased post-traumatic symptomology due to the earthquakes also had parents who had existing mental health difficulties (Liberty et al., 2016). The mass shooting that occurred within the region in March 2019, and it being widely televised, may also be considered a reason why some children presented with poor emotional adjustment to staying at the SIRCO. Studies have shown the fear that even practice lockdowns can produce and the post-traumatic symptoms which can develop in those where there are casualties during a shooting (Bonanno et al., 2021; Daniels & Hyatt, 2018). These traumatic events may have influenced the children and made staying at the facility away from their families difficult, the limitations of this are discussed below.

Implications

The most significant implication highlighted through this study is the severe lack of investigation, at present, into the many issues for children arising from the use of respite care. There are too few studies that seek to understand children's experiences of respite care; and with the findings of the current study, there is a plethora of avenues that would be worth further investigation. There are implications that flow from each of the six subordinate themes to consider how to capitalise on these findings — to uphold and continue the positive experiences and diminish the possible negative experiences. Implications and suggestions need to be held loosely, as the cultural world views held by different families need to be taken into consideration with each specific child.

Theme 1: Constructive experiences

The implications of the current study's findings are that most of children enjoyed the activities during their stay at the facility due to their entertainment and novelty; they also reported positive friendships built over the period. The children had constructive experiences that would provide beneficial developmental cues which included stepping outside their comfort zone in a safe place and positive role models via the staff at the facility. The importance of these findings is that that, overall, the facility — for these specific children — provides a place in which they can have fun, have positive behaviours reinforced, and in some cases, build positive relationships with other children. For the SIRCO in question, these findings suggest that they are giving children activities that they are not able to normally do, creating special memories and encouraging children to explore and experiment with new skills while being supported by attuned staff. The implications of these findings would suggest the continuation of training staff in positive behavioural management skills and ways to best role model behaviours and conflict resolution to the children. The study's findings also highlight the importance of providing children stable and supportive figures that can develop secure attachments with the children.

An implication of the findings of this study is that these constructive experiences provided to the children during their stays are significant for their development. If these experiences are frequent, repetitive, and attuned, they could result in significantly beneficial impacts on children's development over the course of their stay/s at the facility (Perry & Hambrick, 2008). As the Neurosequential Model of Therapeutics describes, repetitive activations of the areas of the brain in a sequential manner — as could be achieved through these constructive experiences — can encourage brain development and the mastering of developmental skills. With the understanding that children who attend these facilities could have forms of trauma that have limited their brains' sequential development, the constructive

experiences during their stay could provide an opportunity and environment for this developmental growth.

Theme 2: Adverse experiences

The implications of the adverse experiences that children experienced during their stay indicates the need for the SIRCO to continue to consider which children attend and when. Children at the facility expressed that some behaviours of other children were worse than what they experience at school. This implies that having clear policies on how to create a safe environment for the children who attend the facility, regarding age gaps between children and personality differences, is vital. This study recognises that skilled employees work hard at making considerations on which children are at the same stays as others and that it is not an exact science.

The implication regarding the findings that the school at the SIRCO was "too easy" for some of children is also important to consider. One possible solution would be for the teacher to ask children to identify themselves if they wished to complete more difficult tasks. Those that did so could be given support by staff to help them with the harder tasks set. These tasks could be ordered according to curriculum levels (which correspond with year levels), although children will not necessarily be functioning proficiently at the year level that their age determines they are in. Nevertheless, more autonomy over what level they are working in may allow the children to be challenged appropriately. Another possible solution might be that for children who are scheduled in for longer stays, such as a week, the teacher at the SIRCO could contact the child's school teacher ahead of time to get some learning material for them relevant to their current studies. This will help them to stay up to date with the rest of their class and alleviate any anxiety they may have of getting behind. Otherwise, an adverse implication of respite care stays — if during the school week — is that it may put children who are already from disadvantaged circumstances at even more of a disadvantage, as it inherently disrupts

their learning and may cause them to have ‘gaps’ in foundational knowledge and skills required throughout their schooling.

Theme 3: Self-beliefs about why they stay

The most important findings of the current study were that parents were framing attendance at the SIRCO as based upon the child’s difficult-to-manage behaviour. Contrary to this, children are placed in these facilities due the parent’s lack of capacity or skill to parent effectively. The implication of this discovery indicates that there is a need for guidance and framework around teaching parents how to speak about the child’s stay at this facility.

The policy implication of this is that both respite providers, and the social services that refer children to these providers, need to re-conceptualise the purpose of this respite care and use language that does not infer these children have difficulties or incur a high burden of care, or that the children are the cause for the need for respite. This would involve changes within the respite care service’s own policy and practice documents and vocabulary. Changes including terminologies used when communicating between various agencies, staff-to-staff interactions, and families. Possibly the SIRCO and refers could encourage parents to use positive language about the facility such as treating it as a reward.

A second policy implication is that both respite services and the social services that refer children to these providers should reconceptualise the purpose of respite for these children, by way of formal policy and practice procedures. Examples include: 1. Replacing the term ‘respite’ with some other term that more accurately describes the purpose of the stay; 2. Providing some training to both types of organisations (i.e. the short stay workers and the social workers in social services) to explain the potential harm that existing concepts and terminology can cause to children’s self-image. Additionally, provide pre-stay advice to parents about how

to describe the short-stay holiday to their children, and counsel parents against inferring that the children are being sent away because they're naughty or are a burden.

One implication might be that a psychologist or counsellor interviews each child at the start and end of each stay so as to gauge how the child felt about the stay; this could then be followed by a recommendation for the length and frequency of future stays. A second implication might be that the length of stays for younger children is shortened. This would allow parents to still get the break they desire but also help children who are younger to cope with the separation, knowing it will only be a single night. In some cases, it may be recommended that the child stay only for the day, if possible.

Theme 4: Attendance autonomy

The implication of the lack of autonomy felt by children who attend the respite care centre has highlighted the possible need for a child's permission to attend the facility. Though the benefits of a break for the under-skilled and/or low-capacity caregiver are apparent, there are methods which could be used to generate buy-in from the child. However, a caution for this would be that if the child is given full autonomy and selects not to attend, it would possibly increase the likelihood of maltreatment (O'Brien, 2001). Conceivably, all that would be necessary is for the child to feel that their voice has been heard and consulted, encouraging the belief that they could participate in choices regarding their own life. This could mean, as a possible example, consulting the child on whether they go to respite care on a weekend (including the selection of which weekend), or in the school term, or during the holidays, and/or giving an option around the length of their stay. The autonomy granted to the child could be as limited as letting them choose between two options, but by doing so, it may empower the child to feel in control of their situation and environment.

If, as suggested earlier, a counsellor or psychologist was employed at the respite care centre, they could conduct an entry and exit interview with the intention of gauging the perceived autonomy of the child. This would give the facility a way to monitor how children felt about attending and help them assess (in consultation with parents/caregivers/guardians or social workers) whether the child needs longer or shorter stays or any other provisions/considerations to aid their adjustment to staying. The counsellor/psychologist would be able to directly communicate their assessment and recommendations to the parents and staff at the centre.

One consideration, however, that needs to be added to this theme is individualist vs collectivist cultural differences, as distinct cultural groups can place varying emphasis on interdependence within the family unit (Eskisu, 2021; Preciado, 2020). "Collective ethnic groups emphasize family interdependence whereas individualistic ethnic groups emphasize autonomy and self-reliance." (Preciado, 2020, p. 20). In the case of attendance, it may well not be as important for a child in a collective culture to be given the individual freedom to choose whether to attend the facility. This study acknowledges that cultural differences should be upheld and endorsed when they support the well-being of the child; however, in the case of this study, children's responses highlighted possible long-term negative impacts that the lack of autonomy had on them. Children from a collectivist background may defer more readily to their caregiver in regard to what the caregiver decides; however, some choice should always be in the hands of the people it most effects.

Theme 5: Wanting to help their parents, feeling responsible for their parents' wellbeing

The implication of these findings are complicated as it is common among families for children to feel a certain level of responsibility or desire to help their parents, particular those from very vulnerable backgrounds (Burton, 2007). These parentification behaviours, by themselves, possibly would not be considered significant enough to justify notification of

Oranga Tamariki. The practical implications of the findings, however, inform the importance of healthy social and relational training of its staff members. This will help staff continue to model and teach healthy relationships and boundaries to the children.

Framing parentification within the understanding of latent vulnerability and the Neurosequential Model of Therapeutics approach to understanding childhood trauma, these findings suggest the need for greater awareness within the SIRCO setting. If a child is living in a dysfunctional home environment where the parents reinforce developmentally inappropriate parentification behaviours then these repeated activations will influence the child's development (McCrory & Viding, 2015; Perry, 2003). As children's brains develop sequentially, the support by staff in the respite care setting could — with adequate training — address the fallacies in the children's beliefs at the age-appropriate stage of the trauma. As stated, this could only occur if the staff were trained and taught the best methods in which to identify and work with traumatised children on an ongoing basis.

Considerations for future research could be to investigate whether these developmentally inappropriate parentification behaviours can be seen during stays where the child may excessively care for younger children even when they do not need too. In applying social learning principles to these behaviours, some evidence has linked this with later onset of caretaker syndrome, showing the importance of tackling this issue in the current setting (Valleau et al., 1995).

As discussed previously, the differences between collectivist and individualist cultural groups are significant with how they approach child-rearing (Eskisu, 2021; Preciado, 2020). Collectivist culture places great significance on the unity and interdependence of a group; this can sometimes be through children performing tasks such as cleaning or cooking. If the tasks are developmentally appropriate, then this can result in positive outcomes for the children

through feeling competent and accomplished. These jobs that the children complete for the family are beneficial and are not parentification. For children of any cultural group where these tasks transition into being developmentally inappropriate and beyond their capabilities, this would then be considered instrumental parentification (Preciado, 2020). Similarly, emotional parentification is when the child fulfils the psychological and emotional needs of the parents and/or the family when it is developmentally inappropriate. This may include a child being entrusted with sensitive information or taking the role of the mediator in family conflicts. The implication that this has for the present study is that there is a distinction that needs to be made between what is developmentally appropriate and inappropriate in regard to children and the responsibilities they take on in the family.

Theme 6: Emotional adjustment to stay

The implications of the subordinate theme of the children's emotional adjustment to their stays is to first recognise that there are many different children from diverse families and backgrounds in the facility. To support children in emotionally adjusting to their stay, respite care providers need to demonstrate attuned caregiving to meet each child where they are at (Perry & Hambrick, 2008). During the interviews, some children explained that they were able to adjust well, and during other interviews children described not adjusting well. During the qualitative interviews, those who were emotionally ill-adjusted to their stay at the SIRCO were less able to identify the positives of the SIRCO. The benefits other children spoke of, like the fun games, enjoyable outings, and attuned and caring staff were spoken about less by these children. The importance of this is possibly the emotional adjustment to their stay and its relationship to the other highlighted themes, such as self-beliefs, attendance autonomy, and separation anxiety. One specific factor that needs to be considered is the child's cultural adjustment to their stay, as — while attending the respite care facility — they may be in a

situation where their culture, language, ratio of adult/child, or ratio of genders is radically changed from their regular living situation. The implications of this cannot necessarily be mitigated but may be a factor in affecting their emotional adjustment to the stay. Furthermore, if children believe they are responsible for their stays and have no control over whether they can choose to come, then it may influence their adjustment to their stay. For these facilities to be most beneficial, children need to feel comfortable and safe while they attend. To ensure this, the current study suggests that further steps are taken by respite care facilities to understand the specific needs of each child and that staff are given basic training in the Neurosequential Model of Therapeutics (or other similar training) on how to identify and work with traumatised children, allowing them to be understood (Perry & Hambrick, 2008). This training would be especially relevant for staff working in respite facilities within the Canterbury region where the children have been exposed to the traumatic events of earthquakes and/or the mass shooting, in addition to the worldwide impact of COVID-19. It is also possible that children who have an anxiety disorder or other forms of internalising behaviours may never fully adjust to their short stays at the facility.

Limitations

There are several limitations that must be acknowledged when viewing these findings. The first limitation is the time constraints that this thesis was conducted in; this was due to COVID-19, permission to conduct the study, and submission dates, all of which may have affected the data collection and analysis. This meant that an even gender split could not be established in the interviews, which could have highlighted different areas when integrating the interviews.

One other significant limitation is that the sample size and selection of participants were from only one respite care facility. This means the generalisability of the results to other such

facilities is limited, and as discussed, there is not one universal mode of respite care, highlighting that these findings may be restricted to this one centre. Another limitation was a possible sample bias as participants were selected through purposeful sampling methods; however, parents/caregivers/guardians were given a choice to opt in or out. With the length of the interview phase being five months to gather 8 interviews and the facility having two intakes a week, it shows that many parents opted not to allow their child to participate. This indicates only a specific set of parents allowed their child to participate and be interviewed, which may mean that only the most well-organised or those willing to let their children speak to a staff member about their experiences at the SIRCO were interviewed, biasing the sample population.

A further limitation was the minimal amount of data gathered on each participant before the interview took place. This was done to keep the privacy of the individual and keep the parent/caregiving involvement low so that they did not find it burdensome. This, however, did not allow the researcher to record and specify any possible disorders or diagnoses that each child had. The interviewer themselves (because of the nature of their work) was aware of the children's personal disorders or diagnoses but was unable to ask the child directly about it, as it did not directly follow the intended questioning about respite care. An opportunity for more history-gathering prior to the interviewing may have provided more details around family situations, culture, religion, and other predisposing factors that may have affected the data.

There is also a possible limitation of the current study with the researcher being a male New Zealand European, which may impact the data gathered due to any transference by the child. The child's responses may have been influenced by other similar adult figures in their life, potentially resulting in them giving answers based on approval-seeking rather than their true feelings. This could mean that answers were skewed in some way, but there was an attempt by the researcher to reduce this possible limitation. The researcher did this by having a long-standing relationship with each participant and building rapport and trust in the interview. It

must also be acknowledged that the researcher is part of their own culture, and this could have meant that there was misinterpretation of the results. By using frameworks and meeting with culturally competent individuals on how to understand and approach persons of different cultures, this limitation was minimized.

As the study hinges on the interviews conducted with the children, there are limitations to the findings (Alsaawi, 2014). The generalisability of interviews is minimal as the participant is discussing their own life and personal views; however, it allows for rich data to be obtained, giving great detail to the experiences of the individual. In the current study, the children discuss many different perceptions and experiences they have of the facility, which are all personal. The indirect and filtered perceptions gathered are a combination of beliefs and values of the interviewee, which are then analysed by an interviewer with their own agenda and beliefs which can distort and create bias. This could be further skewed because the children were ranging in age between 8 to 12, meaning the developmental stages were between that of the concrete and the formal operational stage (Piaget, 1964). This may have meant that some of the questions posed to the children during the interviews were of an abstract nature when the children being interviewed were still in the concrete developmental stage, resulting in children being unable to understand the question. This could have led to concrete answers being given to abstract ideas.

Another limitation was that the semi-structured interviews were the first that the researcher had officially conducted, so questions that could have been leading or which primed the child's response could have been present. During the analysis of the interviews, pruning occurred to remove any leading from the subordinate themes being developed; however, primed responses may have still been present. The lack of previous research on the topic could also be considered a limitation, as if this area were better understood then a superior method of

information-gathering or theoretical frameworks could have been used to establish how children experience and perceive their stays.

A further possible limitation, as discussed previously, is that the children interviewed are from the South Island region, meaning it is possible that the children are experiencing ramifications of the earthquakes or the mass shooting that took place. The traumatic instances of the region may have influenced the children and the answers given in the interviews. This can also be said of the COVID-19 pandemic and the effects it has had on children.

The researcher also needs to acknowledge that they are an employee of the facility in question, and thus, there may be bias in the study and the way it was presented. The study was conducted independently of the facility and the SIRCO was not given an opportunity to read or comment on the study before submission. Attempts were made to limit the researchers bias by working closely with their supervisor to remove all unconscious bias present. However, it must be considered as an inescapable limitation of this study.

Recommendations

The current study primarily indicates the need for further research in the field of respite care and children's perceptions and experiences of it. This study's design was to investigate the voice of the children in an exploratory manner and thus highlight the possible areas for further inquiry in the field. Sufficient qualitative data were obtained in the present study to guide the design of a quantitative survey of children attending respite care in the current context. Ideally, the survey would be administered across multiple services that provide respite for children whose caregivers have parenting difficulties, and would aim to recruit a sufficiently large enough sample to allow for analyses of sub-sample responses e.g. by gender and age. In addition to a cross-sectional survey, further new knowledge might be gained by surveying children's experiences and perceptions of respite over time, using a longitudinal

design. Areas which should also be investigated are: children's self-beliefs about why they attend respite care; children believing they are attending respite care to care for their parent as a form of parentification; the effects of placing children in respite care with other at-risk children in regard to the frequency of their exposure to externalising and internalising behaviours; children's lack of autonomy about their stays; the possible difference in child and parent's views of respite care; whether the beneficial impacts of respite care are outweighed by the possible negative impacts long-term. Further exploration of these areas is needed to ascertain the generalisability of these perspectives.

Children's self-beliefs about their stays are an important point of examination, as there is an understanding that disrupted development in these areas indicates worse life outcomes. Children developing poor self-beliefs and poor self-esteem because of their stays at respite care is an area in critical need of investigation. The reason it needs to be scrutinized is because poor self-esteem and self-worth is correlated with higher rates of depression and anxiety later in life (Sowislo & Orth, 2013). Therefore, the current study has a recommendation of a longitudinal approach investigating the long-term effects of children who attend respite care. Such a study should investigate, firstly, the number of children who have negative self-beliefs about their stays, and then follow these children through their development. If the children believe they are the responsible for their stays at the facility due to their behaviours and are repeatedly separated from their parent figure they might develop abnormal schemas about themselves and the world around them. With the findings of the current study as a guide, there is a significant need to continue investigating children's self-beliefs at respite care facilities.

Parentification of children, as previously discussed, is a possible sign of neglect; and further research should investigate this as a feasible mode in which to highlight at-risk children in families through respite care centres. Further research is needed to quantify the possible number of children that feel subjected to this treatment, with consideration given to cultural

differences between individualist and collectivist world views to minimize the risk of intervention due to cultural bias rather than the negative impact on the child. The current study's exploratory nature allowed for children to highlight this area and now, from it, small policy changes could be made to account for this possible blind spot. Such policy in place would allow facilities a better method of highlighting children in their care that might need further agencies to be involved to support parents/caregivers/guardians with more parenting skills.

Another finding of the study was that children reported experiencing bullies and mean children during their stay. This is by no means unique or surprising; however, in a few interviews they highlighted the behaviours as harmful and unlike normal school bullying behaviours. As has been noted throughout this study thus far, many children who attend respite care facilities are those with increased rates of externalising or internalising behaviours (Bruns & Burchard, 2000; O'Connor & Zeanah, 2003). Children who stay at respite care facilities are, therefore, surrounded by others who might display heightened rates of externalising or internalising behaviours. With what is understood about social learning theory, this study recommends that future research investigates whether at-risk children who attend respite care vicariously learn negative behaviours from other children who attend. This study may make the recommendation that the selection process surrounding the attendance combinations of children be considered, with the intention of minimizing exposure to bullying behaviour for vulnerable children.

The findings of the current study suggest that children feel unable to have autonomy when deciding upon their stay. The reality for many of these children is that it is in their best interest to attend to give the parents/caregiver/guardian a break, allowing the disadvantaged parents a reprieve from trying to manage behaviours they have limited skills or capacity to contain; in doing this, the stay reduces the risk of maltreatment (O'Brien, 2001). The children

in the interviews, however, believed they were at fault (regarding why they attended respite care), identifying they felt little autonomy in their stays. Future research should investigate whether a significant number of children report this lack of autonomy. If this is the case, one theorizes that it could influence the child's perception of their helplessness.

There is also an important discussion to be had about the possible disparity between parents' and their child's perceptions of their stays at these facilities. Read (2008) highlighted the discrepancy between the two groups. When comparing parents to children in respite care, a plethora of studies have investigated parents reports of respite care and their perceived beneficial impacts, but there are few studies that investigate children's perceptions and fewer still report them as purely beneficial, hence the need for a better understanding of the topic. Piaget (1964) propounded that there are varying developmental stages during childhood, with the concrete stage being between 7 and 11 and the formal operational stage being 12 onwards. With many of the children who were interviewed being in the concrete stage of development in both Read's (2008) and the current study, they would have a limited ability to view their stay with an abstract understanding of the benefits for their well-being.

With the questions raised during the current study, further questions could be posed whether the beneficial impacts of respite care are outweighed by the possible negative impacts long-term. This study does not suggest that this is the reality of the situation but must acknowledge that there may be negative consequences as the current method stands. Even though it has been shown that parents are able to care more effectively after using respite care, it may not mean that there aren't underlining long-term impacts on the children sent to respite care facilities. The only way to truly understand whether this is the case is to further investigate the field and conduct a quantitative longitudinal study of the outcomes for children.

A final recommendation may be that the word ‘respite care’ is changed to one that is more appropriate to the service that is provided, as respite care is most commonly used in situations where there is a significant burden of care (associated with the person being cared for) that needs to be relieved. An example of a change might be ‘children’s camp’ or ‘kids’ retreat’ where there is a replacement of the connotations of the children being burdensome with one that is positive and brings with it a sense of a holiday or treat.

Conclusion

In the current study, short-term respite care provided as a support intervention for families with parenting difficulties is perceived and experienced by children in both positive and negative ways. The constructive experiences that they have at the facility include making friends and being able to experience the fun activities provided both at the centre and on outings. Many of the children discussed their excitement and joy about their stay. During the course of all the interviews, however, children also reported that they had negative experiences with the other children being rude or displaying bullying behaviour towards them; in some cases, they reported it worse than at their school. All the children believed that they or a sibling were the reason for their stays, that their poor behaviours or anger issues resulted in them attending. There were some who expressed that they believed they were disliked by their parents, and many shared that they wanted to go home but did not feel they had the autonomy to or feared punishment if they did so. One child discussed parentification-like behaviours, acknowledging that they came because their parent needed a break and that it was their responsibility to give them a break; they also worried about the future when they would be too old to come anymore. Many children reported that they wished they were able to choose when they came and expressed anger or sadness that they could not stay home instead of coming.

Cultural considerations are needed when investigating children and their experiences at the SIRCO and how they can naturally adjust to their stays.

The study has revealed vastly unexplored areas in the field of respite care — specifically regarding its impact on children — which have been largely ignored by researchers; and further investigation into the significance of findings made by this study is recommended. The benefits of respite care centres are clearly defined for parents, but there is a limited understanding of children's perceptions and experiences, which is of concern. The current study's findings suggest a possibility that there could be negative self-beliefs, adverse experiences, parentification, poor emotional adjustment and low felt autonomy for the children who attend such facilities, which potentially may have negative long-term effects on their internal working models and behaviours.

There are limitations of the current study that may have affected the results. The COVID-19 pandemic may have affected the study by decreasing the mental well-being of the participants and their families. The trauma that has been experienced in the South Island region, due to natural disasters also may have resulted in children facing increased levels of trauma. Furthermore, the use of purposeful sampling methods, as recommended by IPA, could not account for families who did not want to participate, possibly resulting in participants over-representing a particular population. There was not an equal gender split in the participants, which may have meant that different themes were highlighted. Participants were across developmental stages, which may have influenced their comprehension of the questions asked. Additionally, the cultural difference between the researcher and the participants may have influenced the answers or the interpretation of the answers.

The recommendation of the study is the need for further research in the field of respite care, specifically children's perceptions and experiences of it. The current study's findings

suggest the need for a quantitative cross-sectional survey to take place across multiple respite care facilities to see if the present findings are significant across the population. Long-term effects of respite care on children's self-beliefs are also an area of significance that warrants further investigation. The children in the study reported poor self-beliefs and many concluded that they were the precipitating factor to their stay. Addressing the language used by parents/caregivers/guardians, staff, and social workers as not to infer that the child is responsible for their stay is an important recommendation of this study. One suggestion is changing the words 'respite care' to another more favourable to the child, such as 'children's camp' or 'kids' retreat'. Children being given some autonomy in regard to their stay is also recommended with a simple implementation of them being given the choice between two different dates, this could help children feel in control of their situation and environment. This change would be culturally appropriate as it still gives the family the choice in deciding when a stay is needed but allows the child to contribute to decisions regarding them. Another recommendation is for staff to be trained in recognising the signs of parentification and being culturally competent to recognise the difference between what is developmentally appropriate and inappropriate for a child. There is also the recommendation of the employment of a psychologist or counsellor at the facility who could conduct entry or exit interviews or to check in each day with the children on how they are finding their stay. This would not need to be invasive but could bring an important perspective to the SIRCO team on how each child is going.

In conclusion the current study listened to the children's voices in the SIRCO and found that, although all of them enjoyed aspects of their stays, there were a number of significant areas of concern. Respite care centres are a vital part of the support systems provided to parents/caregivers/guardians who need to regain their capacity to parent to the best of their

abilities; however, changes are likely required to make the respite care facilities fully attuned to the children they are caring for.

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APPENDIX A.

Recruitment Email

Dear (Parents Name),

We have an upcoming study being conducted at _____ led by one of our very own staff Samuel Kerr for the University of Canterbury.

The study aims to help understand how children feel about having stays at places like _____. All it involves is a single 30-minute interview with (Child's Name) during their next stay.

Samuel does not know you have been contacted and if you are not interested then that is completely fine, and your decision will not impact the services _____ offers to you in any way. This study is not conducted by _____, but it has the approval of our board of trustees and the University of Canterbury's Human Ethics Committee.

If you are interested in allowing (Child's Name) to participate and they are also interested, then please reply back to Sam at ske77@uclive.ac.nz within 5 working days and the information sheet and consent forms can be sent to you for you to read. Sam will also check in again with (Child's Name) that they are happy to participate, prior to the interview. Please be assured that this in no way affects your child's next stay on (Next Stay)

A phone call can be arranged to explain any questions you may have.

Thanks for reading,

_____

_____

APPENDIX B.

Child Information Sheet

School of Health Sciences

Ph: +64 3 3693524

Email: ske77@uclive.ac.nz

Date: 16/9/2020

Ref: HEC 2020/72

A Study of Children's Experiences of being at [name of SIRCO redacted]

Child Information Letter

Dear _____

My name is Sam, I work at [name of SIRCO redacted] and you probably know me from one of your trips there. When I'm not working at [name of SIRCO redacted], I go to a big school called a university and I have a homework assignment called a study that I'm doing.

1. **What is the purpose of the study?**

The purpose is to find out how children who go to [name of SIRCO redacted] think and feel about going there.

2. **Why have I been chosen?**

You are being asked to take part because you have been to [name of SIRCO redacted] a number of times so you have experienced what it is like to go there.

3. **Do I have to take part?**

You do not have to take part in this study, and if you decide not to, you will still be able to come to [name of SIRCO redacted]. If, after you have started to take part, you change your mind, just let me know and you can stop and no information you have given me will be used.

4. **What does taking part look like?**

If you decide to take part, I will ask you some questions about how you feel and think about [name of SIRCO redacted]. You do not have to answer any questions that you don't want to. During the interview I will give you two pieces of paper one with the word 'Skip' which you can hold up to move to the next question and one with the word 'Stop' so that at any time if you hold that up we will finish the interview. If I ask you any questions that make you upset, then you can hold up one of these cards. This will take about half an hour and I will record your answers on a voice recorder so that afterwards I can listen carefully to what you said. If you want a staff member to sit with you and support you then let me know.

5. Will the information that I give you in this study be kept confidential?

I will keep the information in a locked cabinet or in a locked file on my computer. When I write about what I have found, your name will not be mentioned. Your parents will not be able to hear anything you tell me. However, if during our conversation I hear anything which makes me worried that you might be in danger of harm, I might have to tell other people who need to know about this. If you want a staff member there to support, then they also promise not to tell anyone what you say.

6. What will happen to the results of this study?

When I have gathered all of the information from everyone who is taking part I will write about what I have learned in a thesis, which is a long essay, which I have to complete for the course I am studying on. This will be read and marked by my teachers at university. I will tell you and the other children who have taken part what I have found out about [name of SIRCO redacted] if you would like. I will destroy my recordings after I have written down in my notes what you said, and I will destroy the notes when the project is finished.

7. Who has made sure this study is safe?

This study has also been approved by the Human Ethics Committee at the University of Canterbury and [name of SIRCO redacted] via the Board of Trustees have given their approval for the study.

8. Who can I contact for further Information?

If you have any questions about this study, you can ask me, Samuel Kerr (ske77@uclive.ac.nz).
If you have any concerns, you can contact [name of SIRCO redacted] or you can contact my supervisor Michael Tarren-Sweeney (michael.tarren-sweeney@canterbury.ac.nz).

This project has been look at and approved by the University of Canterbury Human Ethics Committee, and if you have any complaints, you can send an email to The Chair, Human Ethics Committee, University of Canterbury (human-ethics@canterbury.ac.nz).

Thank you for reading this.

Samuel Kerr

APPENDIX C.

Parent Information Sheets

School of Health Sciences
Ph: +64 3 3693524
Email: ske77@uclive.ac.nz
Date: 16/9/2020
HEC Ref: 72/2020

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

A Study of Children's Experiences of being at [name of SIRCO redacted]

Parent Information Letter

Dear _____

My name is Samuel Kerr, and you may know me from the four years I've been working part-time at [name of SIRCO redacted]. During this time, I have been studying Psychology at the University of Canterbury with hopes of becoming a child Psychologist. To do this, I have to complete a Masters research thesis, which involves carrying out a small research project, and writing a research paper. I am doing this project at [name of SIRCO redacted]. Over the years that I have worked there I have met many amazing children which has inspired me to want to conduct a study to learn more about how they think and feel about coming to [name of SIRCO redacted]. Essentially, I want to know why they think they go to [name of SIRCO redacted] and how that makes them feel about themselves and the world around them.

I am doing short 30-minute interviews with children. I'm trying to make this as much fun as possible by doing the interviews at [name of SIRCO redacted] while playing board games with them. I have a short list of questions that the I will discuss with them and from their answers about their experiences and perceptions of [name of SIRCO redacted] the study will be written. The interview will be audio recorded only so that I can engage with your child the best and not make them feel uncomfortable with my head buried in writing notes. Only the information your child verbally gives during the interview will be used in the study, no other source will be used You will be able to read the paper once it is complete, but you will not be able to be present for the interview or read the transcript.

Why is the project being done?

I am doing this project because there is currently very little knowledge about how children feel about going to places like [name of SIRCO redacted]. I am hoping to find out how children think about going to [name of SIRCO redacted] and their experiences, feelings and thoughts about themselves when they come to stay. By knowing this it will help inform not only but many other agencies on how to support children better when they are away from their parents.

Samuel Kerr

What would your children's participation involve?

A single 30 minute interview with your child by myself (Samuel Kerr) and another stuff member if your child wishes, on their next visit to [name of SIRCO redacted].

What choice do you and your child have?

This study is voluntary. You are free to withdraw your child from the study at any time without giving a reason, and without consequences. If you withdraw, any information I have saved about your family will be deleted and any paper records I have will be shredded. Your child would also be asked to give their consent before and at the time of the interview. Children can also decide to withdraw from the study during or following the interview.

What if my Child gets upset?

The interview has been designed to be fun and catered to be used with children. The questions are carefully chosen to be insightful but not intrusive. It is a semi structured interview; your child will be able to direct their answers they give and there is no right or wrong answer. Most of the children I am interviewing will already know me. If your child appears upset by a particular question or by the interview in general I will either move to the next question or stop the interview. There will be two pieces of paper one with the words 'skip' and another with a stop sign on it. If they want to move to the next question they hold up the skip sign then the next question will be asked. If they hold up the stop sign the interview will immediately stop. If your child is upset or unhappy in general during the interview, then I will stop the interview and engage your child in a fun activity. The [NAME OF SIRCO REDACTED]

How will your child's privacy be protected?

All the information about your family will be kept confidential and anything your child says during the interview will be kept private even from other staff members. The only exception is in the case of your child disclosing harm or the risk of harm to themselves or others and in this case the practice manager at [name of SIRCO redacted] will be notified. All the information about the study will be kept on a secure computer and in a locked filing cabinet at the university and will be deleted or destroyed once the study is finished. Children will not be named in the research report. There will be no ability for anyone to read the report and identify who participated.

As this study is independent of [name of SIRCO redacted] , the staff there will not know which parents agreed to participate and which parents declined to participate.

How will the information collected be used?

The results of my research project will be written as a University thesis and may possibly be published as an article in an academic research journal.

Who has approved this study?

Samuel Kerr

This is an independent study and is not in any way part of [name of SIRCO redacted]; however, the Board of Trustees have given their approval for the study. This project has been look at and approved by the University of Canterbury Human Ethics Committee, and if you have any complaints, you can send a email to The Chair, Human Ethics Committee, University of Canterbury (human-ethics@canterbury.ac.nz).
If you have any questions about this study, you can ask me, Samuel Kerr (ske77@uclive.ac.nz), my supervisor Michael Tarren-Sweeney (michael.tarren-sweeney@canterbury.ac.nz) or you can contact [name of SIRCO redacted]. If there any concerns contact Michael or [name of SIRCO redacted].

Thank you for reading this.

Samuel Kerr
Master's Student
University of Canterbury
Email: ske77@uclive.ac.nz

Date: 22/01/2021

Supervisor: Professor Michael Tarren-Sweeney

School of Health Sciences

University of Canterbury

Ph: +64 3 3693524

Email: michael.tarren-sweeney@canterbury.ac.nz

Samuel Kerr

APPENDIX D.

Parent Consent Form

School of Health Sciences

Ph: +64 3 3693524

Email: ske77@uclive.ac.nz

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

A Study of Children's Experiences of being at [name of SIRCO redacted]

PARENT CONSENT FORM

☐ I agree to my child participating in the research project and give my consent freely.

☐ I understand that the project will be carried out in the way described in the Parent Information Letter that I received.

☐ I understand that the project is approved by [name of SIRCO redacted] and by the University of Canterbury, Human Ethics Committee

☐ I understand that any personal information about my child _____ will remain confidential to Samuel Kerr and will not be passed on to [name of SIRCO redacted] or any other person or organisation.

☐ The only exception to this is where a child discloses information that leads Samuel to be concerned for his/her safety or for the safety of other people.

☐ I understand that I can withdraw my consent for my child to participate freely from the project at any time without giving a reason.

☐ I understand that I will not be able to be present for the interview or read the transcript of the interview.

☐ I understand that I can contact the researcher Samuel Kerr (ske77@uclive.ac.nz) or supervisor Michael Tarren-Sweeney (michael.tarren-sweeney@canterbury.ac.nz) for further information. If I have any complaints, I can contact [name of SIRCO redacted] or the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

I consent to:

Samuel Kerr

☐ My child being interviewed by Samuel Kerr, as described in the information sheet, during their next stay at [name of SIRCO redacted].

☐ An audio recording of the interview being made, on the understanding that this interview will be destroyed after the interview has been transcribed.

Caregiver's Name: _____(please print)

Signature: _____

Date:

If you have any questions, please contact Samuel Kerr via email. If you have any concerns, you can contact [name of SIRCO redacted] or you can contact my supervisor Michael Tarren-Sweeney (+64 3 3693524 OR michael.tarren-sweeney@canterbury.ac.nz). This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and parents/caregivers or participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

Samuel Kerr
Master's Student
University of Canterbury
Email: ske77@uclive.ac.nz

Supervisor:
Professor Michael Tarren-Sweeney

School of Health Sciences

University of Canterbury

Ph: +64 3 3693524

Email: michael.tarren-sweeney@canterbury.ac.nz

APPENDIX E.

Child Assent Form

School of Health Sciences

Ph: +64 3 3693524

Email: ske77@uclive.ac.nz

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

A Study of Children's Experiences of being at [name of SIRCO redacted]

CHILD ASSENT FORM

(Circle the green thumb if you understand and agree or the red thumb if you do not)

- I agree to talking with Samuel Kerr during my stay at [name of SIRCO redacted].
- I understand that I can stop anytime I want to and that I do not have to say why.
- I understand that before the talk takes place, Samuel will check again that I am happy to talk with him.
- I understand that the staff at [name of SIRCO redacted] think that it is okay for me to talk with Samuel.
- I understand the information I give will not be shared with [name of SIRCO redacted].
- I understand that I can have another staff member there to support me if I wish.
- I understand that if I am not happy with something that happened in the interview then I can tell Sam or his teacher Michael (+64 3 3693524) or talk to [name of SIRCO redacted]. I could also get help to message the Chair of the University of Canterbury Human Ethics Committee, (human-ethics@canterbury.ac.nz).

I agree (consent) to:

- Talking with Samuel while I am at [name of SIRCO redacted].
- A microphone being used to record the talk that Samuel and I have. When Sam finishes writing the conversation into words, he will destroy the recording.

Child's Name: _____(please write)

Signature: _____
Date:

AT TIME OF INTERVIEW

Child's Name: _____(please write)

Signature: _____
Date:

Samuel Kerr

If you have any questions, please contact Samuel Kerr via email. If you have any concerns, you can contact [name of SIRCO redacted] or you can contact my supervisor Michael Tarren-Sweeney (+64 3 3693524 OR michael.tarren-sweeney@canterbury.ac.nz). This project has been reviewed and approved by the University of Canterbury Human Ethics Committee, and parents/caregivers or participants should address any complaints to The Chair, Human Ethics Committee, University of Canterbury, Private Bag 4800, Christchurch (human-ethics@canterbury.ac.nz).

Samuel Kerr
Master's Student
University of Canterbury
Email: ske77@uclive.ac.nz

APPENDIX F.

Oral Briefing Script

Oral Briefing Script

Hello,

My name is Sam, you probably recognise me from another time when you came to [name of SIRCO redacted]. I go to a big school called a university and I have a big homework assignment. For this assignment I have to write about children like you, about how you think about [name of SIRCO redacted] and how you feel about coming. I want to do this so that grown-ups can make things better for kids when they go to places like [name of SIRCO redacted].

Your parents said it was okay for me to ask you these questions and to record our voices. Anything you tell me won't be told to your parents. While we are talking I will give you two pieces of paper one with the word 'Skip' which you can hold up to move to the next question and one with the word 'Stop' so that at any time if you hold that up we will finish the interview.

- Does that make sense to you?
- Do you agree that I can ask you some questions?
- Do you have any questions?

Please write your name on this sheet again (Child Assent Form)

APPENDIX G.

Human Ethics Committee Approval Letter

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

HUMAN ETHICS COMMITTEE
Secretary, Rebecca Robinson
Telephone: +64 03 369 4588, Extn 94588
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2020/72

25 September 2020

Samuel Kerr
Health Sciences
UNIVERSITY OF CANTERBURY

Dear Samuel

The Human Ethics Committee advises that your research proposal "Children's Perceptions and Experiences of being Sent to Respite Care for Short Term Stays" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your emails of 9th and 21st September 2020.

Best wishes for your project.

Yours sincerely

Dr Dean Sutherland
Chair
University of Canterbury Human Ethics Committee

University of Canterbury Private Bag 4800, Christchurch 8140, New Zealand. www.canterbury.ac.nz

F E S

APPENDIX H.

SIRCO Approval Letter

[redacted]
Board of Governance Meeting
30 November 2020

Title: Resolution- Decision re-thesis
Author: [redacted]

Resolution: that the board accepts the recommendation by Senior Management and [redacted] to support Samuel Kerr conducting his thesis at [redacted]

APPENDIX I.

Confirmation of Māori consultation and Approval

Mel Tainui
Thu 3/09/2020 1:53 PM
To: Samuel Kerr

Kia ora Sam

Thank you for meeting with me on Monday the 31st August. I was very impressed with your research and your application.

In relation to our discussion, regarding what works well for Māori and with the possibility that you do have participants who are Māori, I was happy to discuss cultural frameworks with you and offer a reading that could help support your research. I am happy to see this research happen.

Great talking with you Sam and if you need further recommendation happy to support.

Ngā Mihi,
Melany Tainui
Kaiārahi Māori
Te Tari o te Amokapua Māori | Office of AVC Māori
Te Whare Wānanga o Waitaha | University of Canterbury
Waea: +64 03691 083| Ext 91083 | Waea pūkoro: optional